THE INTERNATIONAL JOURNAL OF PSYCHO-ANALYSIS

Vol. XXXII 1951 Part 3

REMARKS ON THE PSYCHO-ANALYSIS OF SCHIZOPHRENIA[1]

By K. R. EISSLER, M.D., New York

The history of psychiatry during the last two decades has shown a significant development in the widespread and almost general acceptance of physical methods in the treatment of psychoses. Only a comparatively small group of psychiatrists and psycho-analysts still believe that psychotherapy should be the method of choice, particularly with patients suffering from schizophrenia. At first glance the disagreement between these two schools of thought may appear to be less extensive than it really is, since many therapists recommend a combination of both methods. Particularly do those schools which pride themselves on their eclectic approach emphasize the necessity of psychotherapy before, during, or after the application of physical treatment. I have always felt this advice to be somewhat indicative of the gulf which separates the two approaches.

Although the eclectics are specific in their teachings as to the choice and technique of physical treatment methods, they are unspecific and vague in regard to the psychotherapy that is to be combined with surgery, electricity or injections. In the literature of the eclectics psychotherapy appears either as a *deus ex machina* which will take care of whatever the physical treatment has not accomplished, or else as an adjunct to enhance the therapeutic efficiency of one of the physical treatment methods. Any deliberation as to what the physical side of the treatment can effect as compared with the added psychotherapy, how both methods work together, which technique of psychotherapy ought to be used under what circumstances and at what time, has escaped my attention when perusing eclectic literature.

This raises the suspicion that psychotherapy has often no precise place in the thinking of those who recommend it.

But when we turn to those who are sympathetic to the psychotherapy of schizophrenics, or who even believe it to be the only proper method of treatment, we may often feel disappointed at finding neither a precise statement of the whole issue in question, nor a reference to the host of detailed problems involved. Therefore it may be of value to present in this paper some of the theoretical problems which seem to have been neglected, even though these may not be new to those who are engaged in the psychotherapy of schizophrenics. Particularly in view of recent publications which refer to the psycho-analysis of schizophrenia it may be appropriate to make some general remarks about theoretical implications of that conception.[2]

I

The first point I want to raise, as I consider it to be one of the most essential in any discussion of a psycho-analysis of schizophrenia, concerns the two phases of the disorder. I

[1] Presented at the Midwinter Meeting of the American Psychoanalytic Association on December 8, 1950.

[2] If in what follows I refer particularly to John N. Rosen's work, this is because his publications show more clearly than those of others the pitfalls waiting for the analyst who devotes his therapeutic efforts to the task of treating schizophrenics. For Rosen's publications see, 'A Method of Resolving Acute Catatonic Excitement', *Psychiatric Quart.*, **20**, 183–196 (1946); 'The Treatment of Schizophrenic Psychosis by Direct Analytic Therapy', *Psychiatric Quart.*, **21**, 3–17, 117–119 (1947); 'The Survival Function of Schizophrenia', *Bull. Menn. Cl.*, **14**, 81–91 (1950); 'The Optimum Conditions for the Treatment of Schizophrenic Psychosis by Direct Analytic Therapy', paper read at the New York Psychoanalytic Society on June 2, 1950.

shall call one the acute phase and the other the phase of relative clinical muteness.[3]

The term acute is here used not in its usual sense of contrasting a phase with its chronic counterpart, but in a pragmatic sense. I use it in this context to describe a condition in which the patient's ego feels itself at one with the schizophrenic symptomatology: in other words, in such a phase the patient's ego surrenders to symptoms and accepts them as valid; it accepts delusions as correct thinking processes and believes in the reality of hallucinations, to mention only two of the more conspicuous symptoms. The ego, furthermore, integrates the disorder to such an extent as to act in accordance with the schizophrenic symptomatology, and therefore the patient usually—though not always—cannot continue his accustomed social pursuits, but must live in a protected environment. In the acute phase the ego cannot divorce itself from its symptomatology and the patient is therefore unable to participate in active work aimed at the treatment of his symptoms.[4]

The phase of relative clinical muteness is a hybrid condition, inasmuch as the patient's ego is no longer completely filled out by the schizophrenic symptomatology. In this phase parts of the ego are still affected by schizophrenic symptomatology while others are relatively free from it. This difference from the acute phase may be due to various causes. Either the intensity of the symptom has decreased or the ego has become stronger, or the whole symptomatology has changed. The patient may have different attitudes towards his symptoms in this phase: he may conceal them, or disregard them, or try to suppress them. Quite frequently, when interviewed during this phase of the disorder, he may deny the existence of any symptoms. It also may happen that the symptoms have changed to others which do not interfere with the patient's social conduct. A patient suffering from a feeling of deadness may be perfectly able to go to work and fulfil a responsible function in the community even though he is suffering from a severe and painful schizophrenic symptom. Or a patient may suffer from the delusion that everyone can read his thoughts or recognize his feelings by looking into his eyes; he then may avoid looking into people's eyes and thus successfully combat the social consequences of his delusion. He may be considered by his environment a bizarre, or timid, or arrogant person, but the consequences of his delusion do not militate against his remaining an active member of the community. The psychopathology of this phase is, of course, quite complicated, and I am alluding only to some general characteristics. In this phase the patient's ego is usually accessible to a discussion of his symptoms. The affinity between ego and symptom is not as intensive as in the acute phase, and the patient's ego can potentially be divorced from the symptom, even if he does not experience the symptom as something pathological.

In checking the literature on the psychotherapy and psycho-analysis of schizophrenia, the reader will find that the overwhelming majority—if not almost all—of the reports concern its acute phase. My contention is that the whole question of the psycho-analysis of schizophrenia can be decided only in the second phase. Psycho-analysis, of course, has made valid contributions to the technique which may be applied during the acute phase. But when an analyst has succeeded in discontinuing the acute phase of the disorder, e.g. if the patient ceases to have his delusions and hallucinations, goes to work, appears symptom-free and never again goes into an acute phase, this alone would not justify the analyst in speaking of a psycho-analysis or psycho-analytic treatment of schizophrenia. The patient has very probably converted his acute symptomatology, with the analyst's help, into a clinically bland form, and the therapist should limit his claim to stating that he has cured or, better, discontinued the acute manifestations of the disease. Such a way of thinking is in keeping with the tradition of psycho-analysis. When a psycho-analyst gets a patient out of an acute hysterical attack or cures an acute conversion symptom he will not claim that he has cured the patient's hysteria, even though that conversion symptom does not reappear for the next two decades. I purposely quote hysterical attacks. Clinical experience shows that the methods of stopping a patient's hysterical attack are not specific. Soothing words, a cold shower, or a flood of swear words may instantaneously bring such an attack to an end. The ease with which acute symptoms of hysteria can often be at least temporarily removed and the unspecificity of methods which may achieve

[3] To be sure, a schizophrenic disorder may take its course entirely either in the first or in the second phase.

[4] These definitions are inexact, but I do not want to burden this discussion by too much detail.

this end are two of the contributing factors which brought this neurosis into disrepute. The acute phase of schizophrenia imposes a harder task on the therapist's acumen, and therefore schizophrenia was viewed with more awe than hysteria, though not treated any more kindly. In following up the sequence of prevailing techniques in the treatment of this acute phase, we can observe the occurrence of changes like the changes in fashion.[5] Much like fashions in general, these temporarily accepted techniques partly grow out of the general historical and societal climate as well as out of the general position of medicine. My point is that there is probably no specific technique for the treatment of the acute phase if the disappearance of symptoms interfering with the patient's social behaviour is made the main therapeutic goal of treatment.

A review of the literature will show that during this phase the patients react to a great variety of techniques. To quote only two extremes, I want to refer to Rosen's technique of so-called direct psycho-analysis by means of deep interpretations, and Federn's technique of manipulating the patient's home environment, frequently without any direct contact of therapist and patient over long periods of time.[6] No statistical investigation is available which would permit a preliminary comparison of the therapeutic efficiency of the different techniques recommended by various authors, but one gains the impression that most of these techniques serve mainly the purpose of discontinuing the first phase of the psychosis. One further gains the impression that, during that first phase, there is a certain proneness in the patient to react favourably if he is offered help in any form which is at all acceptable to him. Bleuler felt puzzled by the observation that patients who had been in a state of withdrawal even for a long time would suddenly get out of that condition, sometimes under the influence of events which appeared to the observer as utterly trivial, such as the visit of a friend. Bleuler felt unable to discover the law underlying sudden recoveries.[7] In going through the literature we further make the astounding discovery that Freud seems to have been the only analyst of repute who never succeeded in 'curing' a schizophrenic patient. Such authorities as Jung and Adler reported that they had successfully treated schizophrenics, and it is indeed a puzzling historical fact that just Freud's technique should have been so inefficient as to leave schizophrenia untouched, although, as we are now informed,[8] he would have needed only to make correct guesses about the patients' unconscious and to convey his 'hunches' to them.

II

In the following pages I want to give a brief account of some observations I have made regarding the therapeutic possibilities during the acute phase of schizophrenia. During one year of my Army service, I was working in the psychiatric ward of a Regional Hospital. According to Army regulations, regional hospitals had to transfer psychotic patients to a general hospital, if possible within twenty-four hours. Since I was interested in schizophrenia, the commanding officer permitted me to keep schizophrenic patients in my ward if they did not cause too great a disturbance and if within one week after admission they had recovered enough for their discharge from the Army to be feasible. I had the surprising experience of discovering that I had to transfer only a few soldiers to a general hospital.[9] The vast majority of those soldiers who unquestionably suffered from an acute phase of the disorder, and who showed in their previous histories those significant elements which we usually expect to find in the history of schizophrenics, responded so readily to treatment that the medical board found them sufficiently recovered to be sent to their home environment. Although the patients had improved to the extent of being able to pass the medical board, none of them had recovered to such an extent that a prolonged conversation with them would not have revealed that schizophrenic symptoms were still present, albeit in a way which is significant of the phase of relative clinical muteness. I have no information as to how long that improvement lasted, and I must assume that a certain percentage of these men relapsed into the acute phase after varying periods of living at home.

---

[5] This was shown impressively by Dr. Phyllis Greenacre in her discussion of Dr. Rosen's paper at the New York Psychoanalytic Society.

[6] See Federn, Paul, 'Psychoanalysis of Psychoses', *Psychiatric Quart.*, **17**, 3–19, 246–257, 470–487, 1943.

[7] Bleuler, Eugen, *Das autistisch-undisciplinierte Denken in der Medizin u. seine Überwindung*. Berlin: Julius Springer, 1919.

[8] Mainly by Rosen.

[9] I regret that I cannot give any statistical data. I started my work with purely practical aims in mind and did not foresee that the ratio of successes to failures might become important in regard to theoretical conclusions.

But the fact that they clinically recovered, at least temporarily, from the acute phase must be significant, and warrants a discussion of the technique applied.

I must emphasize that these therapeutic successes were, of course, favoured by circumstances. First of all, the men concerned were usually young; secondly, they were almost always patients who had gone through an acute phase for the first time; thirdly, they were a selected group inasmuch as they had passed the examination of an indeterminate number of physicians before being admitted to basic training; and fourthly, the acute symptoms had lasted only a short period before their appearance was brought to the attention of the other soldiers. Furthermore, the general atmosphere of that psychiatric ward must be considered. There is no doubt that the admission of a schizophrenic soldier was taken as a challenge to one's therapeutic skill and ambitions, and the patients obtained the impression during their hospitalization that the psychiatrist was intensively interested in their quick recovery.[10]

The surprising finding was that these patients responded to a rather simple, not to say primitive, technique. In a comparatively small number of instances some plain and matter of fact explanations of their symptoms were given when asked for by the patient, but the bulk of psychotherapeutic measures concerned conversations about seemingly trivial matters. However, it would be a grave error to attribute therapeutic weight to the content of these conversations. It became clear that the patient reacted to the therapist's affects and emotions which had an opportunity of manifesting themselves during these periods of contact. Particularly did the quality of the voice seem to play a considerable rôle, and I finally began to experiment by varying the timbre of my voice, watching the patient's facial expression until a positive reaction became noticeable. Thus I gathered information about the external circumstances which were prone to elicit positive responses in the patient. The therapeutic medium, of course, was not restricted to the voice, but extended to gestures and to those activities which commonly convey affection and love, such as feeding. I noticed that the feeding situation offered some particularly beneficial therapeutic opportunities. To feed a schizophrenic who refuses intake of food is an art. The mildest expressions of impatience in the therapist will instantaneously destroy any further therapeutic chances. When a soldier's refusal to eat could be overcome only by tube feeding, he usually had to be transferred to a general hospital. But when spoon feeding administered with tenderness, affection and loving (but not patient) persuasion succeeded, the patient usually showed during the meal or shortly thereafter a definite tendency towards improvement.

Another situation of import concerned the listening to the patient's initial report. It is difficult to describe the phenomenology of listening, since it is a passive function. But there is no doubt that there are good and bad listeners, although both may appear identical in terms of their external behaviour.

Everyone, however, has probably had the experience of talking to someone who gave the impression of concentrating exclusively on one's report and of understanding it although not uttering a word. There is a special joy when the feeling of being understood is conveyed without explicit verbal expression on the listener's side. I noticed that the discontinuance of the acute phase occurred particularly quickly and smoothly when the patient's report had a certain fascinating effect on me, resulting in my feeling moved. The subjective feeling was then comparable to those rare instances when works of art penetrate right to the core of the beholder, who surrenders to the effect of sublime beauty.

The stirring agitation of artistic experience in the therapist has its place in the treatment of many schizophrenics during the acute phase. Many of these patients will respond favourably if approached in the way one approaches works of art from which one expects artistic exaltation.

When thinking of the variety of techniques which I tried during that time, I am reminded

[10] It is perhaps not superfluous to allude to the subjective roots of the therapist's ambition. Since he felt strongly against the application of shock treatment, believing that it is ' a great danger ' for the patient, and he knew that the patient would unfailingly be subjected to that treatment in a general hospital, every new admission of a schizophrenic soldier reactivated a rescue phantasy of early childhood. It is inescapable that childhood phantasies are activated in those who are dealing with schizophrenics in the acute phase. I believe that the content of the early childhood phantasy, the kind and intensity of its cathexis, are among the factors which decide whether a psychiatrist develops the skill of successfully treating the acute phase. These beneficial predispositions, however, may become an insurmountable obstacle in the application of the correct technique during the phase of relative clinical muteness.

of what I was told about a Viennese pediatrician who practised at the beginning of the century. When an infant in his hospital was so sick that its recovery was beyond the powers of medical art he ordered two nurses to occupy themselves consistently with the baby in an affectionate way. The underlying idea apparently was that the maximum supply of affection by physical routes, such as carrying around, rocking, and other means, may have the effect of mobilizing forces which counteract the deadly disease. I had a similar impression that a maximum mobilization of the patient's responsiveness by supplying maximum affection through those channels which were still open, had a therapeutic effect on the acute phase of schizophrenia.

I can scarcely expect the reader to give credence to such a report. How should such a complicated and malignant disease give way to the simplest method imaginable, namely, the expression of loving affection? I would encounter such an objection with the following reasoning.

Firstly, the method is not as simple as it may appear from my description. It is, more frequently than not, quite difficult to find what path is still open in the patient and the kind of stimuli along that path to which he will respond. Secondly, it is not a question of curing the schizophrenia, but of bringing about a temporary cessation of a state in which the environment could not communicate with the patient by the normal channels. Thirdly, I was fortunate in so far as my patients were a selected group in which several prognostically favourable traits were combined. I am sure that patients older than these, or suffering from repeated attacks, or from being in one of long duration, will require more elaborate and complicated techniques. I report my clinical observation because its simplicity may teach what the minimum requirement of the treatment during the acute phase, the *conditio sine qua non*, really is.

III

In the foregoing section, I gave a report of schizophrenic patients who, inaccessible to a rational discussion, readily responded to certain manifestations of affection in the therapist. There was no uniformity in the manifestations which elicited responses. The contrast between the patient's lack of response to a rational discussion and his relative inclination to respond positively to the therapist's emotions, reminds us that psychic processes in general can be subdivided into those which are closer to the primary process and those which have been subjected to the secondary process and therefore manifest themselves quite differently from the former. Psychic processes with few exceptions are never purely primary or secondary. They are usually closer to one or the other. (The more of affect, emotion or passion there is in a psychic process, the closer it is to the primary process. The more it is the product of rational, logical, correct thinking, the closer it is to the secondary process.[11])

It is important to keep in mind that not only one and the same psychical manifestation is the result of both primary and secondary processes, but that in one and the same person simultaneously both kinds of processes can be observed separately; i.e. manifestations which are closer to one or the other group. The reasonable sentences a person utters, the rational actions he performs, are the result of tendencies which have gone through extensive secondary processes. But at the same time that person may scratch his scalp, show a number of gestures and expressive movements of which he may possibly not even be aware, and the voice with which he forms rational sentences may be simultaneously the carrier of a great variety of emotions which in turn are much closer to the primary process than the rational contents of his sentences.

It seems that the schizophrenic patient during the acute phase is unresponsive to psychic manifestations in his environment which have gone through secondary processes; he has lost the capacity of giving meaning to such processes. He can respond only to the primary process in his environment. This rule has many exceptions, but is approximately correct as a general statement, and may serve a good purpose in discussing the psychoanalysis of schizophrenia. We could have obtained this therapeutic rule by deduction. In tracing a schizophrenic patient's history in detail, we are surprised by the large quantity of pathogenic experiences to which he was subjected when in contact with primary processes in his environment. From paranoid patients it is known that they react pathologically to the way others greet or do not greet

[11] I am aware of the insufficiency and limitations of these definitions. For the sake of simplification I am using the term primary process in a broader meaning than is customary.

them, to the coughing, spitting, and scratching that goes on in others. But all these manifestations are close to the primary process. As Freud said, the projection of the paranoid's aggression goes along certain pathways which are mapped out by the patient's environment. 'We begin to see,' wrote Freud, 'that we describe the behaviour of . . . paranoiacs very inadequately by saying that they project outwards on to others what they do not wish to recognize in themselves. Certainly they do this; but they do not project it into the sky, so to speak, where there is nothing of the sort already. They let themselves be guided by their knowledge of the unconscious, and displace to the unconscious minds of others the attention which they have withdrawn from their own.' [12]

In this quotation, I believe that Freud emphasizes the importance which primary processes in the patient's environment have in the schizophrenic psychosis. Moreover, it is rather rare to find a schizophrenic in whose history children, infants and animals do not play a large part. But babies and animals are beings under the domination of the primary process. One aspect—among many—of schizophrenia is the fact that it is the resultant of a large number of primary processes which have occurred in the patient's environment and to which the schizophrenic has reacted pathologically inasmuch as his responses are out of proportion to the stimuli and disregard the socially more valid realm of secondary processes.[13] This thesis enables us to understand why the schizophrenic can no longer function in his environment. Since he reacts almost exclusively to manifestations of primary processes in his environment, and that environment is usually oblivious of these processes and is aware only of the secondary processes which, to the schizophrenic, are meaningless, it becomes evident that the two must get more and more apart. I wish to emphasize that this is only *one* aspect of schizophrenia.[14]

Moreover it may now become understandable why I succeeded with the simple technique which I used in the Army. Actually I had inadvertently tried to organize the primary processes in the patient's environment; I did not impose on the patient with a language which was meaningless to him (secondary processes), but crystallized my contact with him around a nucleus of experiences in which the patient's primary processes had become connected with my own. The other factor which until lately I thought to have been responsible was my carefully trying to avoid having the patient exposed to primary processes of a hostile quality. When he was roaming around freely in the community he only too readily absorbed the direct or indirect manifestations of environmental hostility. During the acute phase the schizophrenic is really particularly sensitized to recognizing the slightest traces of hostility in others.

Since a high percentage of unchecked primary processes in the patient's environment was correlated to hostile feelings it is no wonder that schizophrenic patients are frequently convinced that they are living among people who are primarily aggressive, unfriendly and hostile towards them. I carefully checked in myself all those involuntary manifestations which the patient might possibly and correctly interpret as originating in an unfriendly disposition towards him. I indoctrinated the nurses and ward attendants who came in contact with him to do likewise; and by this means I thought I had blocked an important pathogenic channel.[15]

If we now return to our original problem we may be able to suggest a preliminary answer. It is a fact that a large number of therapists, by the use of a variety of techniques which seemingly have nothing in common, have succeeded in stopping the acute phase of the schizophrenic disorder. Is it conceivable that all these techniques have one common denominator, namely, the use of primary processes as therapeutic tools? There is no doubt that in view of the gravity of the schizophrenic disorder a therapist may be pessimistic and avoid intensive contact with a schizophrenic patient. But on the other hand the gravity of the disorder, its reputation of being incurable, may act as a tremendous challenge to a therapist. May it not be that an indefinite number of therapists

[12] See Freud, S. (1922), 'Certain Neurotic Mechanisms in Jealousy, Paranoia, and Homosexuality', *Collected Papers*, **2**, 232–243, p. 236.

[13] The schizophrenic does not react to *all* primary processes in his environment; he is selective. But the problem of selection would lead too far into the psychology of schizophrenia, which is not the subject-matter of this paper.

[14] The qualifications which this aspect needs are not gone into here because they have no bearing on what follows.

[15] Recent experiences, however, which I will presently mention, have made me revise this theory.

feel reassured in the correctness of their particular psychotherapeutic views and techniques if they succeed in 'curing' a schizophrenic? Can any one doubt that at present, when so many different psychotherapeutic schools are struggling for supremacy, the schizophrenic becomes a person of particular importance to the therapist as a kind of test subject? The schizophrenic's cure promises a therapist a wreath of laurels and the reassurance that he must be on the right track. It is a paradoxical situation. To my mind it is this very attitude of great expectation from the acute schizophrenic's recovery which at one and the same time increases the therapist's chances of successfully treating his patient, but also deprives him of any opportunity of proving his point. It seems that there is no specific method or technique which secures the patient's recovery from the acute phase. Direct psycho-analysis, psychodrama, group therapy and a score of other techniques will lead to success so long as the language of primary processes is spoken to the patient and the therapist's primary processes fit into the patient's needs. The proneness of the acute schizophrenic to react to a manifoldness of techniques is, in my opinion, part of the schizophrenic symptomatology and significant of schizophrenic psychopathology.

However, it would be an exaggeration to say that what is said to a patient is of no importance whatsoever as long as the therapist's primary processes go in the right direction. The content of the sentences may conform to the wider and more comprehensive pattern laid down by the therapist's primary processes or it may interfere with them. The content of sentences spoken to the patient in the acute phase may, of course, become an indispensable adjunct of the treatment, particularly with patients whose acute condition has lasted a long time. But in order to formulate as concisely as possible the therapeutic principle involved, I would say that all the interpretations which, e.g., Rosen gave to his patients would have been of no avail if enunciated in a monotonous voice.

Furthermore, I did not get the impression that in instances in which interpretations were used during the acute phase there was a specific relationship between interpretation and clinical recovery. It may be assumed that another set of interpretations might have achieved a similar result. Since the psycho-analytic theory regarding the id reflects actual processes, the 'psychoanalytic jargon' lends itself beautifully as a medium for conveying primary processes to the patient. But this does not mean that another 'jargon' would not serve the same purpose. I believe that perhaps we are in general too quick to call the analyst's statement to a patient an interpretation. It is true that most of these statements are meant by the analyst to be interpretations, and that the conception of interpretation covers the analyst's volition and intention. But from the patient's point of view that which is interpretation to the analyst may be praise, reprimand, expression of prejudice or love. It takes a long time even in the analysis of neurotic patients for them to accept the analyst's words as interpretations and for the analyst's words to acquire the effect of interpretations.

A perusal of, e.g., Rosen's reports will show that his procedure was carried out in circumstances which do not make it probable that his words were understood by the patient as an interpretation or that they had the specific effect of interpretations in the sense in which this procedure is described in the treatment of neurotic patients. What Rosen, following Federn, called direct analytic therapy amounts to the use of verbalized unconscious imagery as a splendid means of effecting a breach in the walls by which the schizophrenic has isolated himself from the rest of the world.

Therefore it can be summarily stated that in the analysis of neurotics the analyst is using for therapeutic purposes his own secondary processes. He tries to be as rational as possible. In the therapy of schizophrenics during the acute phase, primary processes become the main tool of therapy. The problem then is that of using the primary processes rationally, i.e. to the greatest possible benefit of the acutely sick patient.

IV

I fear I have simplified the whole issue by suggesting an explanation which on closer scrutiny turns out to be no explanation at all, but raises new and even more puzzling questions: Why should the therapist's primary processes have any therapeutic effect at all? The schizophrenic patient is swamped by his own primary processes and absorbed by his vivid feelings and phantasies. What effect does the introduction of the therapist's primary processes have on this pathoplastic constellation? I think that this question cannot yet be answered to our satisfaction, but the following deliberation may

suggest the direction in which we ought to look.

One side of the schizophrenic disorder can be compared to the following, albeit rare, situation in the lives of non-schizophrenics. Let us imagine a person who is cast adrift on an island whose population does not understand his language. The natives talk to him, but become impatient with him because he does not answer in their tongue. They refuse to give him any sign of affection as long as he speaks his own language. When he addresses them, they turn away, and he carries a stigma so long as he insists on his own way of expressing himself. Under such circumstances, a man may become quite excited, he may weep or attack others, or he may withdraw into silence, or he may try to create the semblance of contact by imitation. He thus may try to imitate the sounds he hears but does not understand in order at least to go through the motions of participating in the community. But this castaway will never forget the sounds of his mother tongue, and even after decades of not having heard it the first sound of it will create in him an amazing reaction. No matter who the person may be who speaks to him in words of bygone times, he will joyfully turn towards him, trust him and probably if necessary obey him. Of course the problem of schizophrenia cannot be reduced to the problem of interpersonal communication. But one aspect, namely that of speaking to the schizophrenic in a language which he can understand, is a crucial part of the psychotherapy of the acute phase. The comparison of the schizophrenic with a castaway in a foreign language community is tenable, although it does not contain an analogue to the schizophrenic's withdrawal from reality. It certainly amounts to a simplification of the whole problem of schizophrenia when one overemphasizes that the schizophrenic withdrew from a reality which became unbearable for him. But for a discussion of the therapy of the acute phase the factor relating to the abhorrence of that reality for which the patient has exchanged his new one cannot be overemphasized. It seems that most schizophrenics preserve the capacity of returning to a reality which is structured in accordance with their own terms. It is known that these terms, to enumerate only a few, are narcissistic and are connected with the patient's past, and, most important of all, are not obtainable in adult society. But if by good luck a psychotherapist speaks even for a short while in the castaway's mother tongue, he necessarily must become, if only fleetingly, an important part of the patient's life, well differentiated from the rest of the world which continues to push him into his state of isolation by denying the fulfilment of his one great longing.

When that longing is fulfilled, a real person can be cathected by the patient with narcissistic libido, and at that point the breakdown of the ego boundary, the fusion between ego and world, can be at least temporarily stopped. When the therapist has acquired that position in the patient's libidinal economy, he has by no means become the object of transference in the meaning of that term as used in the neurotic's relationship to the analyst. It is an essentially different relationship which is reminiscent of the state of harmony presumably existing between mother and infant. But this is a construction and should not be taken as more. Yet it seems that once such a relationship has been established, it becomes a point of crystallization around which similar processes take place in respect to other sectors of the world. I think that during the acute phase there is a tendency towards recovery. It is known that schizophrenics during that phase often recover without any ostensible therapeutic measures, and once the process of recovery is initiated, it has a tendency to spread. In spite of that tendency, of course, the therapeutic task of guiding the patient to the point where the acute phase has changed over to that of relative clinical muteness is hard, and it would be folly to rely on self-curing tendencies. But often the success is out of proportion to the smallness of the therapeutic effort, and in such patients one believes that one perceives dimly the effect of some propitious forces which are so utterly lacking in the phase of relative clinical muteness.

I owe thanks to Dr. Hartmann for calling my attention to Madame Sechehaye's publication,[16] which, had it been well known in this country, would have made most of this paper superfluous. Sechehaye evolved a new therapeutic technique in dealing with a twenty-one-year-old schizo-

[16] Sechehaye, M.-A., 'La Réalisation symbolique (Nouvelle méthode de psychothérapie appliquée à un cas de schizophrénie)', Supplément de la *Revue Suisse de Psychologie et de la Psychologie appliquée*, **12**, 1947, p. 96. Preface by Charles Odier. Hans Huber: Berne.
This publication has been complemented in the meantime by the same author's *Journal d'une Schizophrène*, Presses Universitaires de France, Paris, 1950, pp. vii+138.

phrenic woman who had proved refractory to the classical technique. She calls this method symbolic realization. With this ingenious technique she succeeded in restoring the patient who went through a prolonged acute phase of about seven years. The therapist gave in a symbolic way all the wish-fulfilments which were demanded by the patient's unconscious. By consistently furnishing proofs of maternal love, the therapist helped the patient to overcome the injury which she had suffered at an early age—as Sechehaye believes, at a time prior to the formation of an ego.

This technique assuaged the sickness and concomitantly brought the patient into contact with reality. Charles Odier rightly stresses that Sechehaye's method consists in the discovery of a language which the patient can understand. ' The physician,' says he, ' must adapt himself to the sickness.' In Sechehaye's detailed report, I think, one can see quite succinctly how talking with the acute schizophrenic in his own language, provision of wish-fulfilments, abeyance of symptoms and establishing the patient's contact with reality coincide in one act. I believe one is barely possible without the others.

But in spite of Sechehaye's excellent report there is a profound riddle surrounding the fact that apparently many schizophrenics show recovery when they are made to feel certain signs of the therapist's primary processes. It is possible that an early phase of ego development is repeated here. It amounts to a situation in which the schizophrenic is faced with what essentially is his own mirror picture. In one instance at least I was able to collect evidence that the patient's symptoms abruptly ceased when in contact with a person in whom she perceived a reflection of what was most precious to her in herself.

V

Things are quite different in the phase of relative clinical muteness, which I will call briefly the second phase.

If the acute phase is so often dramatic, interesting, at times touching and at others frightening, prone to provide the therapist with the sweetness of omnipotent feelings or giving him a saintly feeling, but always adventurous, the second phase is as often monotonous, if not boring, without movement for long periods of time, replete with the patient's stubborn resistances, with endlessly reiterated reports, unendingly repeated petty complaints, nagging remarks, and certainly always gives the analyst a feeling of utter helplessness and impotence. I am reminded in comparing the two phases of the difference between a modern short story relentlessly moving in the briefest possible time towards a surprising *dénouement* and the volumes of Gautama Buddha's discourses with their endless repetition of identical phrases with a change of perhaps but a single word, and often the original sentence reappearing.

But if the analyst does not permit himself to be discouraged, he will be richly rewarded, and one day he may succeed in seeing the skeleton of his patient's ego, bare of all confusing appendages, clearly drawn before his mental eye. The scientific harvest one can gather during the acute phase is rather poor, and in inverse proportion to the emotional gratification a therapist can derive if his personality is at all suited to such pursuits. The new knowledge, however, which can be obtained during the analysis of a patient in the second phase is practically unlimited, though only the curious can survive the trial to which probably most patients will subject the analyst. All tendencies towards self-cure are gone, and the patient seems to have only one purpose in mind—to preserve the *status quo*. He will appear to accept an interpretation only to make the analyst see that it was lip service. He will deny to-day what he said yesterday, and will be so vague in his reports that after a short while the greatest confusion will prevail. But what schizophrenia really is, what had happened during the acute phase, the reasons for the patient's recovery from that phase, all that can be found out only in the second phase after the often quickly changing and noisy surface formations of the acute phase have been removed.

The acute phase is like a bristling firework which fascinates the spectator and keeps him breathless, but the mechanics of the rockets can be reconstructed only after the display is over and the remaining fragments are painstakingly collected and examined.

The technique which must be applied during that phase cannot be discussed here. I would only say, in regard to the claim that the ' classical ' technique is the proper one, that this is true only in terms of the frequency of the interviews and the patient's reclining position. Since, despite their importance, these concern unessential features, it is misleading to speak of a classical technique during that phase.

Neither does the patient behave like one suffering from a transference neurosis nor does he develop a relationship to the analyst which can be discussed in terms of the neurotic patient's transference. His propensity to return to the acute phase alone necessitates a technique significantly different from that used in the treatment of any of the transference neuroses.

I will give a practical example to show how careful we must be in evaluating the course of therapy during the acute phase and how vastly different our conclusions may become once we look back to that period after having been enlightened by observations made during the second phase.

A thirty-year-old female patient was sent to me for the treatment of her disorder, which undoubtedly belonged to the group of schizophrenias. She had been seen previously by an analyst, but proved inaccessible to the usual technique. Since her psychotic symptoms became rather turbulent, shock treatment was suggested, but the patient's family wanted first to make a second trial of psychotherapy. After approximately ten days of treatment, her condition had been so much changed that she could go to work, which she continued to do consistently from then on.

The technique applied during the initial phase of the treatment corresponded approximately to that which I have already mentioned. Gradually the situation changed to such an extent that she could be put on the couch, occasional interpretations were given, and the deeper meaning of her many symptoms could be discussed. After approximately two-and-a-half years of treatment, she asked one day whether I knew what had made her get out of the acute condition in which I had seen her in the first interview. Since I professed to be ignorant on the matter, she reminded me of a little incident which she remembered correctly, but whose importance I had never recognized.

In order to explain this incident I must add a few of the circumstances under which I had met the patient. A few days prior to the first interview I had been asked whether I would have time to accept a new patient who intended to come to New York from out of town. No preparations had been made for her stay, and when she suddenly appeared in my office I was faced with the task of starting her treatment without anyone assisting in the management of her everyday life. Therefore I was forced to assume responsibilities which were not primarily connected with any therapeutic purpose. I inquired into her financial situation, and it turned out that she carried all her money in her purse. She did not know how much it was, and refused to open her purse to find out. She permitted me to open the purse and count the money, which I did. Now, two-and-a-half years later, she told me that the fact that I had taken over active guidance and did not consider her sensitivities, but went ahead and did what I thought should be done, made such an impression on her that it gave her the first incentive to work her way out of the state of complete isolation in which she had been at that time.[17]

I have rarely been so taken by surprise as when I heard to what she imputed her social recovery. It was diametrically opposed to what I always had thought was necessary to lead a patient from the acute into the second phase, namely the patient's confrontation with a primary process in the therapist which the patient would experience as an expression of affection, and the patient's consistent protection from aggression. But here the patient insisted that an action which she evidently had experienced as an aggression, and one stemming from her therapist to boot, who in my calculation was the key figure in the process of conveying love, had nevertheless had a beneficial therapeutic effect. It did not fit at all into what I had assumed about the problems of the acute phase. Only later did it dawn on me—and this impression was strengthened by Rosen's reports on his technique—that at least some schizophrenics, and perhaps even the majority, show favourable clinical reactions when they are exposed to aggressions of whose friendly nature they are convinced.

Indeed, not all aggressions are experienced as hostile acts. Children sometimes enjoy adult aggression in the form of affectionate bawling out. The problem of friendly aggression particularly in its connection with masochism cannot be pursued here.

It had become impressively evident during the two-and-a-half years of treatment that the patient went through a phase in which she experienced life as a consistently masochistic process and that the overcoming of her maso-

[17] Sechehaye, *l.c.*, p. 37, reports a similar incident in the treatment of her patient.

chism proffered one of the scarcely surmountable therapeutic obstacles.[18]

During the acute phase I had achieved a clinical success by inadvertently mobilizing her masochism. Aside from the effect this incident may have had in terms of satisfaction, I suppose it tied her particularly firmly to me because I had given her occasion for a masochistic gratification without harming or humiliating her, but on the contrary had provided her with the feeling of being helped and protected. The fact that her partner would help her even by attacking her and satisfying her masochism must have been a great relief to her anxiety and had a particularly strong reassuring effect. But looking back I doubted whether I should feel happy about this incident despite its beneficial effect in terms of a quick clinical improvement. Was the lengthy masochistic period following the acute phase perhaps partly a consequence of my technique? Did not the patient and the analyst have to pay a rather high price for a quick clinical recovery? Would it not have been better, even if the acute phase had lasted longer, painstakingly to avoid any possibility of the patient's using her masochistic propensities for the sake of turning towards reality? I cannot answer these questions because I am lacking in clinical experience, but I think one can learn two things from this observation. The technique which was used in order to discontinue the acute phase must not only be evaluated in terms of the speed of the patient's recovery and effect on the patient's symptoms, but also in terms of the traces it leaves imprinted on the second phase. If these traces turn out to make a deep-going treatment impossible and if another technique promises to facilitate the psycho-analytic process of the second phase, the latter should be preferred, even if its effect on the acute phase is less dazzling than that of the former.

Consequently a technique cannot be evaluated at all during the acute phase, but its value can be judged only in an analysis during the second. Such a deliberation, of course, holds true only if we become serious about a *psycho-analysis* of schizophrenia, and do not limit ourselves to the standards prevalent in general psychiatry, which demand of a treatment merely that it release the patient in a state of social adjustment which will not be interrupted by a new psychotic episode. Secondly it becomes necessary to conclude that there are principally two techniques possible during the acute phase of schizophrenia. Comparably with Ferenczi's[19] dividing the techniques of inducing hypnosis into those which are reminiscent of 'paternal' and 'maternal' behaviour, the schizophrenic patient in the acute phase can be approached with maximum affection or with that maximum of aggression which he can tolerate.

This became clear in Rosen's report[20] on a clinically successful treatment of a patient in the acute phase. In the course of the treatment an interpretation was given which made the patient faint. Sudden fainting for psychogenic reasons in the course of a treatment interview is scarcely imaginable unless the patient feels attacked by the therapist. But in spite of the impressive clinical success Rosen achieved with this patient, I doubt the usefulness of such a technique. I would consider fainting spells during the recovery from the acute phase a prognostically bad sign for the final resolution of symptoms during the second phase. Unless schizophrenia is considered a hopeless disorder, so that any method promising a change for the better is good enough, we must also learn to distinguish 'wild' psycho-analysis from *bona fide* psycho-analytic technique in its treatment.

VI

At this point we can no longer postpone answering the ticklish question: What are the criteria of a schizophrenic patient's successful analysis? Since the view expressed here evidently repudiates social adjustment, disappearance of symptoms and absence of relapses as valid criteria, not much seems to remain by which the cure of the disease can be measured. However, although my analytic experiences with patients during the second phase are limited, I venture to assert that once the patient has been brought out of the acute phase and psycho-analytic treatment is continued, the greatest difficulty does not concern the prevention of relapses or the continuation of social adjustment, but the patient's difficulty in attaining insight into the nature of his acute disorder. Even when the patient no longer doubts the morbidity of his present symptoms he will

[18] Again we touch here on a problem that must be dropped as soon as mentioned, but I would like to add that the analysis of schizophrenics may offer at long last an opportunity to study early and archaic forms of masochism. See Bak, Robert C., 'Masochism in Paranoia', *Psychoanal. Quart.*, **15**, 285–301, 1946.

[19] See 'Introjection and Transference.'

[20] Rosen, *l.c.*, *The Optimum Conditions*, etc.

rigidly deny the morbidity of an alarmingly extensive part of those experiences which took place during the acute phases.

Even after prolonged periods of time during which the patient has appeared to show something like insight into the true nature of these episodes, first by accepting it on a hypothetical basis and later giving seemingly true assent, he will suddenly surprise the analyst by expressing a conviction that friends really plotted against him or noises were purposely made in order to annoy him. These flare-ups of surrendering to past memories usually occur at times when the patient is acutely upset. The upsurge of the emotional level apparently leads to a revival or recathexis of past memory systems, including the reality quality they had once possessed. We can occasionally make a similar observation in patients who have gone through a toxic psychosis. They may insist after their recovery on the external reality of those delusional or hallucinatory experiences which were caused by the psychosis. But far more frequently we observe that patients remember the psychotic experience, including the quality of reality which was attached to it during the psychosis, but wonder why they ever uncritically accepted it. It is not evident why the memory systems related to the acute phase of schizophrenia so stubbornly preserve the conviction of reality. In every person there are extensive memory systems which bear the mark of reality yet nevertheless cede to analysis and are recognized by the patient to be to a certain extent phantasies. Dreams belong to this group, and the adult makes surprisingly few errors in discriminating dreams from reality. Many childhood experiences are nearly identical with the psychotic experiences in this one respect. They are remembered as indubitable reality-events, yet nevertheless in analysis a patient will be capable of revising this very point and will gain insight into what were the effects of phantasy, falsification and illusion on his memories. Yet I desire to stress one of the many differences between childhood memories which have reality quality despite their purely subjective origin, and psychotic experiences. The former were formed at a time when the superego was barely or not yet intensively developed, whereas the latter occurred when the superego was fully activated. I believe that the dreamer would have a similar trouble after awakening to that which the psychotic has if during the dream his superego were as fully cathected as is the schizophrenic's during the acute phase.

In my own personal experience regarding the time after the years of childhood it happened only once that I was convinced of the reality of an event which it later turned out must have been a dream. It concerned an order I was given and which I started to carry out the following day until the person who presumably had given me the order proved beyond a doubt that he could not possibly have told me what I believed he had. The content of the dream makes me believe that my superego had been more intensively activated during that dream than was usual.[21] Apparently the participation of the superego in the process of forming memory traces plays a great part. If we compare the relative ease with which a person who has gone through a manic episode gains insight, during the interval, into the morbidity of that psychotic phase with the corresponding difficulty in the schizophrenic's disorder, we encounter again a difference in the degree of the superego's activation. During the manic spell the patient's superego has been reduced, if not completely eliminated, and thus it was prevented from giving its sanction to the reality character of the delusions from which the patient suffered at that time.[22] The schizophrenic's delusions, however, develop only when the ego and the superego converge. This metapsychological deliberation, I believe, is not in contradiction with Freud's genetic view that ' the compulsive belief attaching to delusions derives its strength precisely from infantile sources . . . of historic truth '.[23] It seems

[21] Of course the id also had its say in that misidentification of reality. The reader can be sure that the order I thought I was given would not have been to the greatest advantage of the person from whom I claimed to have received it.

[22] During the interval the patient gains similar insight into the morbidity of the depressive phase when the ego is dominated by the superego. In this instance the reality character of the delusion stems probably from the superego alone, and again the convergence of ego and superego resulting in the schizophrenic's delusion is missing.

[23] Freud, S. (1937), ' Constructions in Analysis ', *Collected Papers*, **5**, pp. 358–371, p. 370.

that once the superego has added its consent to the ego's claim for the reality character of a perception or event the ego can divorce this quality only under rare and exceptional circumstances from the respective memories. This may help to explain why some religious people claim not only to know of God's existence, but also actually to see God (without hallucinatory experiences) and are unable to maintain even a temporary doubt as to the real existence of a supernatural being. I may lay myself open to criticism by attributing to the superego such an extensive influence on perception and memory, but I must say that to my mind the superego is an organization constantly effective functionally as long as the ego is awake, and traces of it, I believe, must be found in all ego functions. If the little that is known about the perceptive world of primitives and about their thinking processes is considered, we cannot easily believe that the great variety of different forms are exclusively correlated to differences in ego organization, but they are probably likewise the effect of an equally large variety of superego organizations.[24]

Of course my suggestion does not touch the generally accepted statement that perception as well as memory are ego functions. But the superego tries to interfere with these functions, and the ego carries out the superego's command, or defends itself against it, or makes a compromise. Those processes in which the perceptive system submits to the id are perhaps better known. In the instance of the schizophrenic's insistence on the reality character of past delusions it concerns a certain quality of perceptions which becomes indelibly attached to certain memories and the ego's ensuing inability to doubt the correctness of that quality. It is interesting to compare the schizophrenic's unshakable conviction in that respect with the ease with which the compulsive-obsessional patient can produce doubts about contents of irrefutable reality. But in that neurosis the ego and the superego are in constant discord. The influence of the superego on memories is well known in the case of repression. In that instance the superego refuses to sanction the reality of a memory and forces the ego to delete it. Freud, by saying that 'the superego . . . becomes also a representative of the real outer world and is thus a model for the ego's endeavours'[25] emphasizes the superego's contribution to the ego's strivings. Every act of perception and recall in the adult contains active strivings, and in each of these acts there is a potential judgement on what is and is not, on what is true and false. Apparently once the superego sanctions or ratifies the correctness of ego-important judgements implied in perceptions, reality loses the possibility of exerting a corrective influence on the result. This hypothesis, of course, leads to certain assumptions regarding the psychology of schizophrenia, which, however, would take us far afield from our subject.

The other feature which can be taken as a reliable index of a cure in schizophrenia concerns certain emotional states. Often the rich and colourful symptomatology of a schizophrenic patient becomes reduced to the occasional appearance of a state in which the ego loses its full feeling of activity. These states may show up in the form of the patient's feeling like an automaton or of having lost his personality.[26] Even if such feelings are only of short duration, their appearance vitiates the claim that a schizophrenic patient has been cured. The standard must be more rigorous in this case than in the neuroses. A neurosis is a potentially curable disorder. If after a psychoanalysis some minor unresolved symptoms remain in a patient, this does not militate against that general statement. However, the grave question of whether a schizophrenic patient suffers from a curable disorder is still moot. Among those who appear in statistics or detailed reports as cured or improved, there may easily be an undetermined number of patients who achieved their 'normal' behaviour on the level of an automaton. We must not underestimate the difficulty in obtaining the patient's report on those feelings. Often they are not considered by him as worthy of discussion, or he is afraid of concentrating on them for fear of a relapse, or is not fully aware of them. Most patients feel grateful towards the therapist who has succeeded in rescuing them from the throes of an acute condition, but gratitude may result in

[24] For the participation of the superego in reality testing see Robert Waelder, 'Ætiologie und Verlauf der Massenpsychosen', *Imago*, **21**, 1935, pp. 66–91; *idem*. 'Die Bedeutung des Werkes Sigmund Freuds für die Sozial- und Rechtswissenschaften', *Almanach der Psychoanalyse*, 1937, pp. 130–159.

[25] Freud, S. (1924), 'The Economic Problem in Masochism', *Collected Papers*, **2**, p. 264.

[26] The psychopathology of these states is certainly quite complicated and I have selected two examples at random.

reluctance to admit psychopathology. Strange as it may sound, the apparent change from psychotic to normal behaviour may occur on the basis of a delusion. I must even say that the insidious danger of the patient's adjustment on a delusional basis is quite great; and when a patient who has suffered from delusions starts to speak about reality in a seemingly non-delusional way, this must not be accepted at its face value. The therapist must be alert to detect whether the patient is not merely evaluating and judging reality on the basis of a new set of delusions which are better adapted to making reality-adjusted judgements.

The following example may demonstrate how such fallacious impressions may originate. A patient insisted for a long time that children were afraid of her because her presence had a poisoning effect on them. After a while she reports with a happy smile that children are friendly and in good contact with her. Her description sounded as if she had overcome her previous delusion of harming children. However, closer scrutiny showed that the patient now had the delusion of possessing a power which was particularly beneficial to children. In reality she had merely achieved a change of index in her delusional system. Yet the former delusion had the social effect of isolating her from the community, whereas the latter brought her closer to her fellow men.

I want to choose only one example from the many encountered in the literature in order to show how far therapists may move from the true issue of schizophrenia. I refer to Dr. Melitta Schmideberg's discussion of Rosen's paper.[27] She achieved 'full cure with two patients, a boy of sixteen suffering from paranoid dementia and a schizophrenic man of twenty-three, both of whom were followed up for a period of nine years. Both fell in love, married happily and were able to handle difficult situations.' The technique employed by her is described as follows: 'I . . . interpret whatever material I get. I analyse delusions, hearing of voices, etc., just as I do a neurotic symptom. I try above all to analyse the aggression and anxiety . . .' as if anxiety and aggression were the decisive characteristics of schizophrenia, or falling in love, happy marriage, etc., were beyond its pale.

The tendency to approach the schizophrenic as if he were a neurotic becomes clear in such remarks. This tendency is evident in Rosen's work also. What he describes as the reasons for the schizophrenic's symptoms can be found likewise in neurotic patients. No doubt he seems to think that the various incompatible id impulses are the instigators of schizophrenia, overlooking that it is the ego's way of functioning which makes a patient a schizophrenic. In each case of schizophrenia, if we want to speak of an analysis, the specific ego disturbance must be found, and this again can take place only in the second phase. It takes a very detailed scrutiny to find out which function is disturbed and in what way. Before a patient has discovered and gained insight into the specific dysfunction of the ego it cannot be said that a psycho-analysis has started, because the patient has not yet acknowledged the existence of the ego's basic defect even though he knows by heart the long list of his pregenital impulses. The work which must be done in finding out the specific disturbance of the ego is comparable to Goldstein's analysis of functions in patients suffering from diseases of the brain.[28] If a patient cannot read, or shows any other gross disturbance, this does not tell much about which function has been really injured, since the injury of any one of a variety of functions may lead to the same result. Likewise the patient may learn to read although the diseased function has not recovered, but he may have learned to make better use of other functions which will conceal the persistence of the original dysfunction. It would be an error to believe from the foregoing that I consider schizophrenia an incurable disorder. I only want to emphasize that this question does not appear to be resolved in any of the reports I have seen concerning the successful treatment of acute schizophrenics. The extent of the lesion which the ego suffered may be reduced; other functions may compensate to a great extent for what has been lost. The ego may have learned to conceal the injury. But all this would not yet disprove the existence of a psychic scar within the framework of the ego. Yet we can speak of a psychotherapeutic treatment of schizophrenia as a psycho-analysis only if the existence of such a scar has been considered.

VII

In this section I wish to present a few problems which at first glance may appear to be

[27] *l.c.*, *Psychiatric Quart.*, **21.**

[28] Goldstein Kurb: After effects of Brain Injuries in War. (New York, 1942.)

disconnected but nevertheless have a factor in common. All these problems may show how meaningless a statement such as the cure of schizophrenia is as long as the patient's disease has not been most carefully investigated in terms of the genetic, dynamic and structural aspects. In his excellent study, Stärcke [29] discusses briefly the psycho-analytic treatment of schizophrenia. He refers to a case of paranoia successfully analysed by Bjerre. However, Stärcke believes that Bjerre's report does not prove the treatability of paranoia by psycho-analysis because the patient's father had died during the treatment period. I consider Stärcke's remark an eminently astute one, showing a particularly fine sensitivity for the psychology of schizophrenia. Where does one find in recent psycho-analytic literature on schizophrenia a deliberation which shows equal clinical acumen? Indeed, one can confirm Stärcke's argument by observation. Frequently an event to which the observer would attribute the value of a trauma has a paradoxical effect on a schizophrenic. In particular, the death of a parent may often initiate a clinical improvement. Follow-up studies frequently evaluate the degree of improvement in treated schizophrenics by enumerating the difficult situations through which the patients went without harm. This method, however, betrays a gross misunderstanding of the disorder if the therapeutic effect which those very situations may have had on the patient is not considered.

We can scarcely escape the impression that the simplification which the problem of therapy has undergone in general psychiatry—where the therapist keeps his eye fixed on the symptom and feels satisfied when he can record its disappearance—has penetrated into the thinking of some psycho-analysts, so that there is danger that some of the differences which have distinguished psycho-analysis from general psychiatry may vanish in the course of time.

There are many other problems involved which need careful consideration in each single case.

Freud has described three different phases of the disease, which may briefly be called the phase of withdrawal, the phase of internal elaboration, and the phase of restitution.[30] The schizophrenic process is initiated by a withdrawal of cathexis from external reality, the resulting overflow of mainly narcissistic libido is bound by reorganization within the ego, resulting in hypochondriasis, megalomania and allied symptoms. Next the ego may again push towards reality, i.e., try to recapture reality on its own terms, usually with the result of the production of a delusional system.

Clinically we see that a patient may be in all three phases at the same time. Libido may have been withdrawn from part of reality, but other parts of reality may have escaped the process of delibidinization. Part of the withdrawn libido may be kept bound by ego reorganization, but part may have found a channel in the pathological return to a delusionally distorted reality. The time relations are also of interest. Sometimes, as far as one can see in a general clinical evaluation, the three phases are gone through rapidly. It seems as if the ego had fought a long time to keep up its interest in the world, then a sudden collapse sets in and a delusional system is quickly established. More often the period of withdrawal is clinically mute, long-lasting and not noticed by the patient's environment, often not even by the patient himself.

Furthermore, and perhaps most important in this context, the first phase may not be gone through completely. It is not easy to describe such a course except figuratively. There are many patients who in their withdrawal of libido from external reality do not go through the whole withdrawal process, i.e., they do not reach nor go through a phase of internal elaboration, but stop the withdrawal somewhere between the ego and external reality, and switch to the third phase without having passed the second. In other words, these patients have formed delusions in a short-cut manner before having converted fully reality-directed libido into narcissistic libido. Clinically these patients have the following appearance: they are replete with delusions, but they respond fairly quickly and well to explanations. They will reach the office delusional, but leave the therapist relatively free of delusions. The following day, however, they will appear with the same or a different set of delusions as the case may be. Frequently they are not aware of the repetitive character of the course their interviews take. Sometimes it takes a long time before they even notice the regular change which occurs after

[29] Stärcke, August, *Psychoanalyse und Psychiatrie*, Int. Psychoanal. Verlag, Leipzig, Wien., Zürich, 1921, p. 64; p. 5, footnote.

[30] Freud, S. (1914), 'On Narcissism: An Introduction', *Collected Papers*, **1**, pp. 30–59.

interpretations have been given. The relative lability of their delusions, their quick response to explanatory interviews are due, in my mind, to the lack of a full internalization of the withdrawn object—directed energy. The therapeutic success with such a patient must be clinically evaluated in a different way from that of a patient who has gone through all three phases of the disorder.

Another point which must be considered is the depth of regression. Unfortunately this subject is usually discussed in terms of id regression. However, I am convinced that a prognosis or evaluation of the seriousness of the disorder cannot be made in terms of whether the patient is smearing fæces or is orally fixated. The decisive point is the extent of regression in the ego and the possible destruction of higher ego functions. This may sound paradoxical, because one can scarcely imagine a regression in the id occurring independently of a corresponding ego regression. This objection is valid, but must be taken with some reservations. Within the realm of neurotic psychopathology we also see that id regressions may be correlated to a variety of ego disturbances. Not always is an anal regression combined with a devastated ego such as that in compulsive-obsessional neuroses. The ego may accept the anal regression, the superego may be tolerant or stunted in its development, and therefore regressive id processes need not always effect a serious ego pathology. Likewise we observe schizophrenics in whom the ego surrenders temporarily to the onslaught of a tempestuous id, but the ego functions remain relatively well preserved and only too ready to function again as soon as an appropriate external reality lends its support against the enslavement by id forces over which it had lost control. I would like to suggest the following comparison. An honest man may suddenly discover that he is living in a group of gangsters. He may get frightened and therefore blind himself to what is happening around him. To an outside observer he will possibly appear like a regular member of the gang, because he continues to share the company of criminals, but in reality he only continues his usual pursuits, indirectly condoning the unlawful events going on around him. Under the same conditions a man may become an active member of the gang and he may enjoy his new activities to such an extent that he does not intend to give them up even after the whole gang is caught. But even in the former alternative the man will probably not entirely escape some effect on his moral standards.

If the ego were left completely intact by the psychotic episode, one should not speak of schizophrenia, but rather make use of Berze's helpful diagnosis of schizoid psychosis.

Excluding this special group, we find a variation in the depth to which the ego participates in the acute phase. The most dangerous process within the ego's pathology concerns the destruction of higher, synthetic functions. It seems that the disorganization of these functions yields an important addition of narcissistic libido which had been caught by separate ego functions. Consequently not all of the increase in ego libido results from withdrawal of cathexis from external reality. Some—and I think that which is most difficult to cope with therapeutically—stems from the ego itself by virtue of the breaking down of higher structures. This free narcissistic libido is absorbed by the visual or auditory apparatus or by thinking. Consequently an over-cathexis of these functions takes place. But the clinical aspect must be viewed under the double aspect of the increase of cathexis of the function *per se* and the abolition of a higher regulating centre. The effects of the two processes converge. Then the patient's perceptive functions may become independent and run away with him. The eyes start to dominate the patient's life, or the patient may become a slave of his ears, and the ego must concentrate and devote itself entirely to keeping away auditory stimulation because the whole auditory system is in a state of intensified excitability.

Or ' it ' may start to think in a patient and the ego loses control over one of its most useful tools. Likewise a single set of memories may become overcathexed, etc. Again the effect of therapy must be differently evaluated, according as it concerns a dysfunction entirely due to withdrawal of reality cathexis with full preservation of higher synthesizing functions or a dysfunction with temporary depletion of higher functions, but preservation of their intactness, or thirdly with permanent damage to the higher functions. Of course the mere recathexis of external reality will unburden the ego of damaging cathexis and have a wholesome effect on functions over which the ego had lost control. But such improvement would not necessarily be accompanied by a full restoration of higher integrative functions. Whether these are

adequately functioning or not can be determined only in a prolonged treatment and after microscopic observation of the patient when exposed to a great variety of emotional strains. No doubt a patient may quite successfully cope with his personal and social reality without having reached the maximum level of his pre-morbid personality.

Another important aspect which I think is neglected more frequently than not must be considered in evaluating therapy. Freud has described the schizophrenic's experience of the end of the world as the result of the withdrawal of libido from the outer world. We can observe clinically that either the whole cathexis is withdrawn or that owing to a diffusion of energy only the libidinal cathexis is lost, the aggressive cathexis remaining bound to the representation of external reality. Then external reality suddenly takes on a hostile appearance. The patient feels threatened by an imminent danger without forming the idea of the world ending. Reality then still exists, since part of the cathexis remained bound to its representation, but the appearance of reality underwent a change which arouses fear in the patient. At that stage the patient often appears to be delusional, but the clinical evaluation must be quite different from the delusions belonging to the third phase. If a therapist has the good luck to reach the patient in that phase his endeavours may be crowned by a stupendous success, but would it be correct to make the general statement that he ' cured delusions ' without qualifying in which stage of the disorder the patient was? I will demonstrate these differences by a clinical example. In taking the history of a patient far progressed in the third phase, I found as the initial experience of her psychosis the following. She was on a vacation with her baby boy, sitting in a forest. Suddenly she had the feeling that something uncanny was going on in the trees in whose shade she was resting. She got frightened. She had the feeling of a hostile force preparing something against her and she ran away in great fright. She discontinued her vacation, went back to her home and temporarily escaped the initial onslaught of a malignant psychosis.

However, the way she spoke about her delusional experiences in the forest, the whole standing of that experience in the course of the psychosis, was so significantly different from the delusions of the third phase when she was suffering from the impositions of an influencing machine, that we cannot but assume quite different metapsychological processes in the one and the other instance. Of course the therapeutic chances would have been infinitely better if therapy had begun immediately after the first appearance of acute hallucinations and delusions. It was of interest to see how by a self-chosen change of environment the patient could bring the acute psychosis to an immediate though temporary stop.

It must be added that most of these clinical facts can be ascertained only after the patient has been brought out of the acute schizophrenic state. Even then it needs long exploration and the most careful analysis before each detail of the disease can be put into its proper place.

It would be ridiculous to claim that our clinical or phenomenological knowledge of schizophrenia has progressed sufficiently to make it possible to decide by clinical observation whether a patient's delusions are part of the third phase or the initial stage, as in the instance just described. As with tuberculosis, the schizophrenic process may take its full course or may come to a standstill at any point of its development. What I called the initial stage may persist over years or rapidly change to a full-blown third phase.

It may now be possible approximately to correlate the two treatment phases with those of the disease. The therapy of the acute phase concerns mainly the undoing of the third phase of the disease. Both treatment as well as disease phases are colourful, dramatic, interesting, and fascinate the therapist, the patient and his family. The second phase of the treatment concerns the undoing principally of the first phase of the disease. Treatment and disease are during these phases uninteresting on the surface, arduous and long-lasting.

Just as it was mainly the third disease phase which aroused the psychiatrist's interest, so the therapists likewise concentrated in their treatment on the acute phase. But it behooves psycho-analysis to bring light into other and as yet little explored phases of the disease as well as of the therapy.

VIII

A concluding remark may be made about the personality of the therapist if he is to have a good chance of successfully treating the acute phase of schizophrenia. He should believe in his own omnipotence; therapeutic failure must

be unacceptable to him; the patient's recovery must be of high emotional importance to him; the whole gamut of emotionality must be at his quick command; the activation of psychic manifestations close to the primary processes must be uninhibited; he must be endowed for dramatization; time spent on the patient must not count; the gravity of the situation must challenge him and the possibility of failure must mean to him the imminence of a traumatic, therapeutic defeat.

Then the patient will feel that he has been placed in the centre of the therapist's life. The higher the stakes which the therapist places on the patient, the greater will be his response.

I feel quite sceptical about the miracles which are reported in the Gospels. But I am convinced that the Saviour cured schizophrenics in the acute phase. Like most psychiatric reports the Gospels also omit the tidings of the second phase. Nevertheless, the more the therapist can evoke in the patient a modern approximation to the Christ image, the greater will be his therapeutic chances. I only wonder why the Churches which usually guard their prerogatives with jealousy, so easily surrendered to science the privilege of treating schizophrenics. In this context I am reminded of Gertrud Schwing.[31] When performing her remarkable work with schizophrenics at the University Clinics in Vienna, everyone who watched her was deeply impressed by that aspect of her personality. Like a mediæval saint, she released the schizophrenics from their straitjackets, and patients who had just been howling immediately quieted down when she turned towards them. There is no doubt that some personalities have the distinguished quality of spreading a richly structured background atmosphere. Without saying or doing much they will create, by virtue of their mere appearance, a large number of associations in their partners. The effect they have on others always goes beyond what they directly say or do. It concerns a non-analytic problem, namely what it is that in a person is responsible for an effect which is close to fascination on others.

In those who became famous for their therapeutic effect on schizophrenics such as H. S. Sullivan, this quality could be observed, and I believe that it concerns one of the prerequisites for the treatment of acute schizophrenics. Those personalities whose effect on others depends on the content of their verbalizations will have a much harder time with acute schizophrenics than those whose personality relief *per se* implies a wealth of vague or definite associations, or in other words who easily elicit primary processes in others by implication. There was an archaic language of gesture and purely vocal quality which once steered human relations before the cumbersome, albeit more reliable, system of secondary processes and of rational, logical verbal sentences came to attenuate the contact between persons. This archaic language again moves into the centre of the relationship of therapist and acute schizophrenic in adaptation to the patient's approach to life which is close to the level of the primary processes.

(Received August 24, 1950.)

[31] See Schwing, Gertrud, *Ein Weg zur Seele des Geisteskranken*, Rascher Verlag, Zürich, p. 135, 1940, and Federn, *l.c.*

THE STRUCTURAL PROBLEM IN SCHIZOPHRENIA: THERAPEUTIC IMPLICATIONS [1]

By MILTON WEXLER, PH.D., KANSAS. TOPEKA MENNINGER FOUNDATION

Love in all its myriad forms still stands as the principal prescription for the treatment of schizophrenia. Affection and sympathy, tenderness and approval; these are the medicines of choice. Dosage, of course, depends only on the capacity of the therapist to give, and he is the best therapist who has the greatest libidinal resources. To all of which one might ask: How can it be that such a commodity so lavishly expended can be so potent? Or, how can it be that so potent a commodity is so lavishly and incautiously prescribed?

I believe that Eissler (3) is right when he indicates that the love and patience we would shower upon the psychotic is connected developmentally with earlier phases of contempt and enmity. Few things are so calculated to terrorize at least some schizophrenics as untimely affection, however real and unambivalent. Indeed, the same is true of some skittish children who can be won only by disinterest. If the veriest show of encouragement can be translated by a neurotic in the analytic situation as a seduction, its counterpart with the schizophrenic may be perceived as a rape. Love is no doubt an effective medicine but, as Freud indicated, many effective medicines are poisonous in nature. We must have caution how we use it.

I have a special interest in this problem, for I have been through two years of hell-fire and heaven with a schizophrenic patient [2] who could, on occasion, speak the violent language of a jungle tigress. One gets introspective in the face of such assaults (afterwards of course) and begins to think about the attitudes which call them forth. If some more helpful attitude can be discovered and made explicit, the temptation exists to cast about for theoretical explanations. This is the temptation to which I have succumbed.

At some future time I will present the treatment of this case in some detail. For the moment a few historical facts and some brief abstracts from the electrically recorded treatment sessions will provide sufficient basis for my present speculations and a discussion of the pertinent literature.

Nedda is now forty years old. She was hospitalized early in 1943 and had been continuously in an institution from that time until treatment began in June, 1948. The diagnosis of hebephrenia seemed substantially applicable to her condition in 1948, although paranoid ideas were certainly plentiful. The diagnostic problem is not of prime relevance here, except to convey that the patient was regarded as a chronic schizophrenic and had not proved amenable to a variety of treatment programmes, including electric and insulin shock and a number of kindly and even fairly persistent attempts at psychotherapy.

During my first ten months of working with Nedda I was not markedly impressed by the effectiveness of the therapeutic measures I employed. To my kindliness and what I felt to be an affectionate interest in her welfare, she responded mainly with crude sexual overtures or violent rage and overt attack. Parallel to and intermingled with such raw instinctual gestures was a puritanical saintliness which had its own peculiar quality of violence.

To my persistent pointing out what was real and unreal in her productions, she responded either with queer symbolic expressions or rigid and stereotyped paranoid ideas. Deep interpretations, which were on occasion offered with all the rapidity of my own free associations, brought from her, most frequently, blank denial, anger, or indifference. The main positive result of this tumultuous period seemed to be in the growing interest the patient manifested in being with me, demonstrated not only in her behaviour but in delusional formations in which I occupied a central position.

In March, 1949, ten months after the intensive psychotherapeutic treatment began, I took up a position with respect to the patient's productions

[1] Paper presented to the Topeka Psychoanalytic Society, June, 1950.

[2] My research on the problem of the psycho-analytic therapy of schizophrenia has been conducted with the support of the Menninger Foundation, supplemented by grants from The Lester H. Hofheimer Estate and The Pepsodent Company.

which I had not previously attempted in any consistent, self-conscious way. This new position was taken up partly on an intuitive basis, partly because of some theoretical considerations which had been growing on me for some time. The theoretical basis I will present shortly. For the moment I would like to set out the events of a single session during this month, as well as some later observations with similar implications.

Early in this session Nedda complained of priests and nuns who refused to get up and dress and just wanted to sit there and play with themselves. She said, 'If I had my life to live over again I'd never be a Catholic.' She then referred to the hospital and spoke angrily of the patients in the ward as whores, suggesting that she would never have come to this hospital if she had known they would be around. She 'thought sure it would be different when I got here'. Then with intense feeling she spoke of masturbation. 'I hate it, I just hate it, I absolutely despise it. That's why I hate myself. Every time it enters my mind, I just hate—that's why I can't enjoy life, because I hate myself.' It was at this point that I decided to agree with the patient and when she referred again to masturbation as a sin I injected the comment, 'a terrible, terrible sin'.

Nedda's immediate response to this statement was to say, 'It's serious to abuse your own body, let alone abuse somebody else's body. And you know I can't do that. I'd rather have a fight. Just a common fight. I just hate. I just hate the wrong kind of sex. I just despise it.' Adding piety to piety, I avowed, 'Sex is bad anyway'. Now Nedda said, 'I know it. Well, I was cured.'

The patient was so quiet, agreeable, and relaxed at this point that I ventured further on the same course. I knew she was very disturbed by the open sexual activity in her ward, and said to her, 'But it must be terrible to see those people around here who do it.' To this she responded thoughtfully, 'I don't know if they do it or not. I examine my conscience and I know they do. They say it's responsible for all insanity.' Having abandoned interpretation in the usual sense, I continued to agree with her conscientious scruples concerning sexual behaviour and felt almost immediately that she responded by becoming more communicative and in many respects more reasonable.

Almost for the first time in the therapy she became somewhat introspective about what had happened to her. Statements such as the following were quite new in her treatment and seemed to represent a struggle to reach some realistic appraisal of her situation. 'Well, something's happened to me because I always, pretty nearly always when I was outside, I would pray, say prayers that I'd get immediate relief. Something's happened, and I don't know what it is.' A few moments later she added, 'I used to have the nicest temper and best disposition. And every time I think about that I—I know I can't kill myself because that would be another sin.' And again, 'I don't know what to do. I sit over there and think a lot of something going to happen, something, uh, something will happen.' I thereupon enjoined her against the sin of thinking about me or some other soul in a sexual way. Having bad thoughts about us would make her no longer sure of getting relief from prayer. I told her I wanted to help her to get well, that we had to stop the bad thoughts, and even suggested that if it would help her any I would pray for her that the bad thoughts would stop.

With this suggestion, Nedda agreed quite heartily and *laughingly said that all this should have happened right from the beginning!*

We were smoking, and in a burst of moral enthusiasm I suggested it might even be a temptation and a sin to continue with cigarettes. At the moment she agreed, and then became doubtful, making the statement that she would hate it for a man to lose his business since, if people stopped smoking, the business of people who sold tobacco would be injured.

I had here cynically overstepped the mark, but it nevertheless brought a statement from Nedda which had in it a new and strange quality. She said, 'Maybe I try to be too good. I don't know.' Feeling that Nedda was becoming more courageous in assessing her situation, I pressed forward on the same tack. I insisted that we ourselves should avoid all temptations and thoughts about sex. Together we entered a period of agreeable moralizing and condemnation of evil, into which, from time to time and to my delight, the patient injected a note of rather realistic scepticism. For example, when we discussed the forgiving of one's body for sexual temptations and I spoke of the need for forgiving my own body for its evil enjoyment of sex, she corrected me mildly, saying, 'Well, it (sex) may be right, I don't know.'

A bit later she went beyond this and said, 'I don't know whether somebody made those rules that I'm going by, if they're fanatic, or whether that's right. I'm at a loss as to which is correct.' Immediately afterwards she said, 'I know it's nature to be passionate.' I entered a cautious agreement and she added, 'To have sex, I know that's natural.—But to use it—I don't know if—what about that?—I believe that—I know right now I'm not in a condition to use it.' Then she offered her reason: 'I have a hurt feeling in here (pointing to the region of her heart). I'm sorry, but I have a hurt feeling in here.'

What followed in this session frequently approached the same introspective note. She spoke of herself as having been angry and impatient with her sexual thoughts and feelings. She indicated that I could not depend on her judgement, that she was kind of guessing at things. She really didn't know if a man would like her as well if she had had

sexual intercourse before marriage as if she were a virgin. She didn't have nerve enough to indulge in sexual behaviour. It made her nervous and she felt like getting up and walking off.

This kind of talk from the patient, even though interspersed with schizophrenic productions, represented a very marked change from previous communications. I had not previously encountered such a reasonable attitude, such an ability to communicate personal thoughts and feelings. I was intrigued with the notion that something in my moralizing, something in this agreeable condemnation of frightening impulses, was responsible for the change. Nedda was verbalizing better, took a more sensible attitude towards her own impulses, and seemed to be dealing with reality situations far more effectively than in any previous session.

In subsequent sessions I went much farther. Having reached the point where I verbally agreed with the patient that sexual and aggressive manifestations were sinful and therefore to be eliminated; having even offered myself as an agency for prayer that such sins be stopped, it was no great leap to offering myself as a more active agent in the prevention or suppression of their occurrence. From this point on in the treatment I took a very active part in forbidding any sexual or aggressive provocations which threatened to disturb the therapeutic relationship. If Nedda threatened to use force against me, I made it clear I would employ an equivalent amount of force against her. When, with rapidly diminishing frequency, I was actually assaulted by her, I did what I could to immobilize her. When the physical provocation was severe enough to arouse in me strong resentment and a wish to put a quick end to her assaultive behaviour, I did more than inhibit her movements. I fulfilled my promise to meet force with force. I can say this about our struggles together: With but one exception, never did any of our vehement verbal and physical battles end without peace-making and affectionate exchanges of devotion; rarely did she omit to thank me for putting an end to the threatening and overwhelming forces which had seized control of her.

I would summarize the course of events in the following way: Almost every struggle with the patient has led to clinical improvement as this can be judged by increased reality testing and diminished anxiety and guilt. Every such clinical improvement was followed up by me with a relaxation of demands upon the patient, and with increased dosages of affection, interpretation, and education. Until recently, every such relaxation of the relatively strict, demanding, sometimes punitive, sometimes moralistic atmosphere has tended to bring on some disturbance of the patient's equilibrium and has necessitated the reinstitution to some degree of the former psychological position. The main line of progress has been forward, and, like the frog who jumped up three feet and fell back two in getting out of the well, we now observe a considerable amount of daylight immediately ahead. It seems enough to say that this chronic, hospitalized patient whose weird dress, bizarre manner, and assaultive behaviour presented such an impossible problem in her ward, has been living in a foster home for the past nine months, travels alone to daily therapeutic appointments, does quite complex work in ceramics, helps very efficiently in the home, and above all seems in the process of surmounting the severe thought disorder with a rapidly increasing differentiation between objective reality and her subjective thoughts.

I have several grave concerns about presenting and elaborating on these clinical observations. The first relates to the fact that I am concentrating on only one aspect of the treatment, and it may be lost sight of that many other elements in the treatment are necessarily omitted. I would not wish it to be understood that these few observations constitute the key to the improvement of this patient or that broad generalizations can now be drawn concerning the treatment of schizophrenia in all its variegated aspects. Furthermore, my concern extends to the possible misuses of the theoretical considerations I wish to present. Whatever the provocation or the theoretical necessity, it is not easy to acknowledge, outside the context of the total treatment situation, isolated incidents involving the use of physical force in the management of the patient. And, as you are already aware, there is much in what I have to say which will easily lend itself to interpretation as an endorsement of acting out on the part of the therapist in his relationship to schizophrenic patients. However, as Winnicott has recently pointed out (25), there is always the problem of hate in the counter-transference, most especially in the treatment of psychotics. I can only hope with him that such hatred becomes less of a counter-transference problem and more of a sorted-out, conscious, and objective experience. Only then will we be able to use our hatred, our fears, our urges to dominate and master, as instruments of our love and therapeutic zeal.

What I have indicated so far is really nothing so new in psycho-analytic literature. It is merely undigested and without adequate placement in the theoretical frame of reference. I should like to illustrate how easily we overlook this aspect of our work by citing a recent case report offered by Hayward (15).

We are told that one day Hayward's schizophrenic female patient stripped naked and

began making forceful sexual advances. Having previously been impressed by reports of Rosen's work, Hayward now met the sexual attack with a barrage of interpretations. Following these interpretations the patient quieted down, dressed, and discussed the interpretations with the therapist in some detail. Immediately afterwards a marked clinical improvement was noticeable.

Hayward makes the following comments concerning his interpretations:

> 'Hindsight shows an outstanding and very injurious error in the management of this case—namely the handling of the transference relationship at the time of the sexual attack. The reader can see that the therapist changed abruptly from a clarifier into a forbidding moralist, saying in effect: "Get away from me, I am married." Instead of this he should have continued to clarify the situation by asking, "Why do you like me so much?" And, "How will intercourse help you?"'

How strange it is that Hayward should apologize so strenuously for an approach which apparently resulted in the patient's improvement. He seems uncomfortable with his moralizing and rather convinced that he needs to explain himself to the profession for failing to behave in some preconceived 'psycho-analytic' manner. I would prefer to think that whether we are 'psycho-analytic' or not depends neither on the clinical outcome nor on professionally stereotyped attitudes. For me it depends solely on the conscious utilization of metapsychological principles to guide and explain the therapeutic endeavour.

This brings me back to a statement I made earlier. I said that some theoretical considerations had prompted my taking up a position with respect to the patient which might easily be characterized as oscillating between superego and ego-ideal representative. I would emphasize again that this position was only occasionally maintained and much more than this went on with the patient. But I speak with great certainty when I say that clinical improvement followed hard on either kindly or sharp condemnation and rejection of the patient's crudest instinctual impulses, especially when these threatened to come to motor expression. How can we see such harsh and punitive treatment within the framework of psycho-analytic technique and psycho-analytic metapsychology?

Fenichel (8) provides us with a metaphor for the treatment strategy which I consider to be applicable only to the psycho-analytic therapy of neurotics. He writes:

> 'The unconscious impulse which pushes towards consciousness and motility is our ally, the defensive ego our enemy. But we are in the situation of a commander whose troops are separated from his allies by the enemies' front. In order to unite our forces with those of our allies, the warded-off instinct, we must first break through to him, and for that we need another ally acceptable to us, the reasonable ego, which must first be detached from the defensive ego. To remain in the metaphor, we must first disintegrate the enemies' ranks with propaganda and win over large portions of his forces.'

In psychosis, it seems to me, the situation is rather reversed. What we need to resurrect and bring from hiding, is an ego which has become separated off from a world of reality and for which, to varying degrees and in varying ways, cathexis of external objects has become impossible. If we ask ourselves what it is which separates us in our therapeutic endeavours from access to an adequately functioning ego, then I think clinical observation suggests the following answer in many instances of schizophrenic psychosis. *Between us and the ego which has abdicated its legitimate function of reality testing lies a turbulent and chaotic battle-ground where instinctual impulses of many varieties threaten constant eruption even in the face of unremitting superego pressures which threaten annihilation as the measure to be paid for the least gratification of such impulses.* In the face of such a devastating conflict, with death as the seemingly inevitable outcome, it is the ego which has abandoned the struggle for control, lost its interest in the external world, and given itself over to fascinated and horrified subjugation to the life and death struggle between psychic instances which have proved more powerful.

If in a general way, and at least for certain phases of the illness, psychological forces are deployed in this new fashion, we are confronted with a therapeutic task which is quite different from that in the treatment of neurosis. In the latter instance we need first to break through to the warded-off instinct and for this purpose we seek to ally ourselves with the remnants of a reasonable and critical ego. In schizophrenia, on the other hand, our need is ordinarily to break through to and resurrect remnants of a reasonable ego, and our ally will necessarily be something lying nearest to the surface, closer to

our reach, more accessible to our propaganda, seductions, or injunctions. In short, it is our task to shift the balance of forces by throwing in our weight either on the side of the id or on the side of the superego. Neutrality would be as futile as if we were to maintain a controlled impartiality between the executioner's axe and his block in the hope thereby to save a head from rolling.

For purposes of simplification I have chosen to ignore a number of important considerations. I am well aware that even in the psychotic we are always working in and through the ego, an ego which is now largely given over to an incessant and horrified watch of the id-superego conflict and to efforts at restitution. (The complexity of that ego organization and the variability of its functioning is such that I will do no more at present than describe it with such a loose and no doubt faulty anthropomorphism.) I am also well aware that a schizophrenic psychosis represents no static internal or external conflict and that the answer to the question of when and to what extent and to what side in the id-superego struggle we lend our strength depends largely on economic issues which I am not now prepared to discuss. I have also chosen to neglect such problems as the strong masochistic trends, regression of the superego to primitive and archaic forms, and issues concerning constitutional predisposition. At this time it is impossible to do more than acknowledge some of these problems. Perhaps additional clarification will come if we turn our attention to the rich clinical and theoretical material to be found in the literature.

Erickson and Kubie (4) have provided us with a report of the treatment under hypnosis of an acute hysterical depression which comes quite close to being a model for the aspect of technique I am discussing. In three hypnotic sessions a most remarkable change was effected in a patient. I would like to focus on one aspect of their approach in which, as the authors noted, ' treatment proceeded along lines which are the reverse of the usual psycho-analytic technique '.

The following passage will make this evident:

' Although it was clear, almost from the start, that the patient's passive and submissive dependence upon the mother's commands would have to be broken, it was equally evident that the image of the dead mother played a role in her life which overshadowed that of any living person and that this idolized superego figure could not be dislodged from its position by any direct frontal attack. For this reason, the hypnotist's stratagem was to adopt a point of view as nearly identical with the mother's as he could. He had first to identify himself entirely with this mother image. Only at the end did he dare to introduce a hint of any qualifying reservations. Therefore he began by giving the patient immediate and emphatic assurance: " Of course you always will be a good girl." Then in a manner which was in harmony with the mother's stern, rigid, moralistic, and forbidding attitudes (as judged from the patient's manner and words), each idea attributed to the mother was carefully reviewed in the same terms, and each was earnestly approved.'

So went the first phase of the hypnotic treatment. In the second phase, the therapist made the point that the patient's mother had died when the patient was thirteen years old. Had the mother lived she would then have told the girl differently, would then have allowed more and freer expression of her sexual purposes. The attack on the superego began, then, with complete support of its most repressive features. Only later was the rigidity and archaic punitiveness of this structure undermined. In this case the clinical outcome was excellent.

I am reminded of a spontaneous statement made by my patient, Nedda. In discussing the sinfulness of sex, she said, ' I think they tell you it's a sin until you're a certain age, I imagine.' We shall all be reminded, no doubt, of the resemblance the treatment bears to a common child-rearing problem in which the effective atmosphere for proper ego functioning is the creation of clearly definable boundaries and restrictions which may subsequently be relaxed following the growth of ego strength. More specific, though still quite relevant, are the views of Anna Freud (10) that an excessively permissive form of upbringing does not differ in result from dictatorial, prohibiting forms, since the expectation of sexual partnership by the child is not realized. The most complete tolerance towards infantile masturbation may then not have the anticipated effect. This is particularly true when the child experiences the adult's failure to participate in its sexual activity as an actual rejection.

Knight (16) gives most pertinent advice in his report of the treatment of a catatonic schizophrenic. To my mind it is advice steeped in the same clinical acumen which permeates the Erickson-Kubie report.

' Therapy in such a state must, therefore, be a vigorous and persistent intrusion of the therapist

into the patient's trance, forcing him to make contact again with an object. Affection, interest, sympathy—all the good attitudes of the good therapist may not be enough to pierce the daze, and must be supplemented by physical contact, an insistent voice, and a forcing of the patient to focus his attention on the therapist.'

And again:

'Some comments have already been made about the necessity, in such a case as this, of active firmness on the part of the therapist in breaking through the barriers of the trance and defiance. Firmness has further values. It makes the patient feel more secure from his own "bad" impulses if he can count on the therapist adding his considerable strength in the struggle against the "bad" impulses. Thus a too permissive or indulgent attitude on the part of the therapist may lead the patient to feel that he is without an ally, helpless against his own overwhelming hates, defiant feelings, and primitive erotic wishes, and a prey to the intolerable anxiety they cause him. The protective strength of the therapist may thus be experienced by the patient as reinforcement of his own enfeebled ego, making it possible for him to contemplate eventual success in his struggle if this good ally will stay in the fight.'

These therapeutic recommendations are at odds with a number of ideas on technique advanced by Federn and Fromm-Reichmann. For the moment I would prefer to consider a theoretical issue which Knight does not touch upon except by implication. I refer to the topographical problem. Freud (11) differentiated neurosis and psychosis by indicating that in psychosis the conflict between ego and id is solved by severing the relation to reality and by yielding to the instinctual unconscious, the id; in neurosis the conflict is solved by severing relations with the instinctual unconscious and by saving the reality relationship. Does this statement imply that schizophrenia is essentially an inundation of the ego by rampant id forces with a corresponding dilution or disappearance of superego functioning? Knight, of course, lays principal emphasis on the need to contain and control the instinctual impulses, and mainly in the reference to schizophrenic anxiety is the possibility of a structural conflict hinted at. But then Knight's superbly clear report is primarily clinical, with technical recommendations for treatment. Theoretical issues of this nature were not central to his purpose.

Alexander (1), on the other hand, deals with the problem more directly. He states:

'One may define the chief difference between a psychosis and a psychoneurosis by stating that whereas the psychoneurosis is chiefly a conflict between the different structural parts of the mental apparatus, in psychosis the relation of the mental apparatus to the external world is disturbed in a pronounced manner.'

Later he says:

'Hallucinations and illusions, in general, do not presume such an inner conflict between super-ego and ego tendencies; they simply are solutions of a conflict of the ego with external reality. Therefore, I called this mechanism more infantile because it corresponds to an early stage of development, in which the conflict between subjective demands and reality is not yet internalized as a conflict between subjective demands and super-ego.'

Alexander then makes some exceptions for paranoid delusions and paranoid hallucinations, in which the threats of the superego are projected into external reality. However, with respect to such hallucinations the concept of regression is introduced to explain that it is not really an internalized superego structure which is in conflict with other dynamic tendencies but rather that there is a return to a childhood period in which the ego was controlled by external persons, forbidding and punishing parents. Alexander finds it unjustifiable to regard the impulsive self-mutilations of schizophrenics as self-punishing reactions induced by a harsh superego. He asks how it is possible for the same schizophrenic person who has lost such fundamental functions of the superego as pity and disgust, who indulges in coprophilic satisfactions, to retain the exquisitely moral reaction of the need for self-punishment.

I have no doubt that self-mutilation in schizophrenics has little in common with the 'exquisite morality' of the ascetic. I would also accept the explanation that such self-mutilations are partially determined, at times, by passive feminine wishes. But to explain them wholly as expressions of 'disorganized instinctual demands that have lost their interconnexions' is a travesty on the clinical picture of schizophrenia which often reflects some of the most brutal morality I have ever encountered. Certainly we are not dealing with a superego intact in all its functions, but a primitive, archaic structure in which the primal identification (incorporated) figure of the mother holds forth only the promise of condemnation, abandonment, and consequent death. Though this structure may only be the forerunner of the

superego which emerges with complete resolution of the œdipus situation, its outline and dynamic force may be felt in both young children and schizophrenic patients. In this primitive and defective structure there may be little or no vestige of love, little or no remnant of the ideals which characterize a later stage of superego development. Nevertheless, a savage, self-destructive morality, either internally directed or projected to the outer world, is rarely missing. And if we do not see it, I suspect it is because we have not yet learned to recognize the most archaic aspects of its development.

I used the term ' defective ' superego a moment ago with the purpose of calling attention to the brilliant theoretical argument advanced by Pious (19), to whom I am greatly indebted for help in every area of my research. Pious refers to the view that the superego serves to restrain pent-up aggressivity (or mortido). It functions as an elastic container so that increases in its tension affect the ego organization, producing a pressure towards activity which would tend to bring about a reduction in superego tension.

Pious then asks, what if the superego is defective?

> ' It would no longer act to contain the mortido, but instead, the mortido would flood the psychic apparatus. . . . There would be no pressure on the ego-organization to undertake aggressive or adaptive behaviour. Instead, just as in an organic illness, the libido would be drawn away from its attachments in the ego-organization in order to neutralize the mortido.'

There is some difference between what I have been saying about the savage, archaic superego of the schizophrenic and the defective superego postulated by Pious. I am not yet able to resolve that difference or to provide adequate clinical data upon which to make a choice. On a number of occasions I have heard schizophrenic patients report experiences which duplicate the clinical data upon which Pious based his formulation of the pathogenic process in schizophrenia. Nevertheless, whether one accepts the version of a superego which is aggressive towards the ego or a defective superego which fails to contain the mortido, the basic emphasis is the same. Moreover, the clinical implications are the same.

What are these clinical implications? In the first place the reduced, fragmented, and defective ego functions are seen as a product of an internal structural conflict among all psychic instances and not simply as a disturbance in the relation of the mental apparatus to the external world. Our task is, on the one side, to deal with the poorly controlled id-impulses which threaten always to seize the channels of motility. On the other side it is our task to foster those primitive identifications which are nuclear to superego development. In this latter effort we may sometimes behave like the hypnotist of the Erickson-Kubie case, preliminarily agreeing with the rigidities of the archaic superego figures. At other times we may offer ourselves as a superego figure (perhaps more properly, ego ideal) which, as Brill (2) mentions, is a precipitate of ' the consoling, loving mother '. At all times we would do well to bear in mind the value of Knight's advice to compel ' the patient to focus his attention on the therapist '. We should see this advice in relation to the conception of Pious that the ' mental image ' of the analyst functions as a superego, tending to seal off the pathogenic process in the psychosis. And, finally, we should recognize that the observations of Freud (12), Rado (20), and Strachey (24), identifying the superego as the fulcrum of psychotherapy, hold true for schizophrenia as well as for neurosis.

Federn (6) recognized the importance of the superego in schizophrenia, but mainly he emphasized the masochistic guilt feelings and needs for self-punishment which are psychotically satisfied in paranoid and catatonic states. He also understood the danger of passivity (5), and cited the case of the analyst who neither encouraged nor discouraged the patient's free associations but listened quietly to a growing stream of erotic, delusionary ideas. ' He was allowing the patient free outlet and was taking the case history while the psychosis developed.'

In other respects Federn reached conclusions concerning the treatment about which I have considerable doubt. He emphasized the establishment of positive transference and indicated that treatment was to be interrupted when transference became negative. In this he went so far as to suggest that the schizophrenic patient must be allowed to go to another analyst when he did not wish to continue with the one who was treating him. A proviso was made here that some motherly nurse, whom Federn characteristically employed in the treatment, might attempt to make the patient understand

his inconsistency and change his mind. But she, too, was under the injunction not to suggest continuation lest this destroy the patient's transference to her as well.

Can you picture what it would mean to treat an angry, rebellious, and helpless child in this fashion? He threatens to run away from home and, if mother cannot make him understand the inconsistency of such behaviour, father quietly sanctions his leaving. Not for me and not for my children! I would not grant them such a terrifying power over their environment at the moment when their most frightening and uncontrollable impulses threaten expression. We may be justified in our reality fears of some psychotics. We are not justified in permitting such fears to invade the whole of our relationship so that we are never able to face squarely and deal firmly with the negative transference.

Forgive me for a personal anecdote. Some time ago my mother objected to the fact that I wished to make a certain recommendation to a physician who was treating a schizophrenic patient in whom my mother had a strong personal interest. The recommendation was simply that the physician should actively put some brakes on the negative, hostile, tempestuous acting out which characterized the patient's behaviour at the time. My mother's feeling was that such behaviour could be dealt with only by sincerity, kindness, love, understanding, and a host of other verbal shibboleths which, though valuable as abstractions, say not a thing about the kinds of behaviour which will communicate such sentiments.

' Mother,' I said, ' how would you feel if you were suddenly made the governor of New York State? ' ' Why, I'd die of fright,' she said. ' And that,' I said, ' is what it is like for an unprepared and weak child to be made governor of the household with unprecedented power to gratify its wishes. It isn't love but fear, and sometimes hatred, which makes us abandon the child (and the patient) to his own emotional devices. You must sometimes hold the baby, and hold it tight, or it will be too much frightened by the rage and lust inside.'

I suppose there are some who will appreciate the thesis I am developing only as a circuitous and rationalized return to mediæval treatment methods. Perhaps they will be tempted to link the sometimes forceful control of instinctual expressions with the brutal exorcizing of devils in primitive psychiatry, with the whipping post and the dungeon. Deep down there may be some relationship. There is, however, also a relationship between the blood-letting barber of several centuries ago and the modern surgeon. We should not be embarrassed by the relationship, but rather inquire what unconscious insights led to such approaches and what fears led our predecessors to place their remedies in such a brutal cast. The dynamic unconscious operated even in pre-psycho-analytic psychiatrists. It was merely discovered by Freud, not created by him. And we should not be so ready totally to discard our history with contempt and horror, however justified these feelings may be. After all, what we know about mediæval treatment for psychosis is mainly the savagery of some of its methods and very little of its clinical experience.

We might even look a little closer home and wonder about the scientific objectivity of some of our own procedures. I have in mind the use of such a debatable technique as vasectomy in the treatment of schizophrenia. Wagner-Jauregg and Federn had some disagreement as to why vasectomy had some curative effect with young schizophrenics. Federn put principal emphasis on the increased libido supply through the Steinach effect. Wagner-Jauregg saw the explanation in the diminished masturbation. I feel relatively sure the effects are due to more complex phenomena than are inherent in either explanation, but I would certainly see the curtailed sexuality of such (unnecessarily) sterilized patients as one avenue along which the ego has ventured forth from hiding. Federn himself saw the necessity for giving deliberate and direct advice concerning the sexual life, and urged the ' control of autoerotism '. (7).

Aside from what effect this will have in terms of libido supplies, I believe we should not lose sight of the relationship between our behaviour as educators and the creation of an auxiliary superego, a partly externalized, perhaps later totally internalized ' mental image ' which will act to contain or at least to diminish the threatening instinctual eruptions. This same could be said for many of our educational procedures. Too often we conceive of the persistent explanations of reality we give to the schizophrenic as if our words appealed directly to and increased the cathexis of some reasonable ego. We sometimes overlook the fact that educative procedures are, in childhood, designed to act as curbs on free instinctual expressions, to postpone the gratification of pleasure, and to build the structure we refer to

analytically as the superego. It is not strange, therefore, that persistent educational procedures followed with schizophrenic patients sometimes prove quite effective. The reason, however, does not lie in the acquisition of rational attitudes and knowledge through rote learning. I would suggest rather that it lies quite largely in the employment of an attitude which is genetically significant for superego development and reinforcement.

Eissler (3) remarked on the Babylonic confusion which exists concerning the diagnosis of schizophrenia. This is largely a derivative of our chaotic understanding of the disease process itself. As a corollary, the technical recommendations for treatment have all the orderliness of a Donnybrook Fair. I will address myself to a narrow aspect of the problem simply to indicate the luxuriant contradictions which lie at hand for harvesting. Schilder (22) speaks of extensive changes in the superego of schizophrenics, with the development of primitive tendencies to cruelty and self-punishment. Menninger (17) refers to the behavioural symptoms in psychosis as ' self-destructive techniques, in which a part is sacrificed to save the whole.' Federn (6) refers to the schizophrenic's guilt and the unreasonably distorted influence of the superego. Eissler (3) remarks on the dangers of increasing the guilt reaction in schizophrenics. Nunberg (18) says that the ego of the schizophrenic suffers in a manner similar to that of the melancholic, from self-reproaches of his conscience, although here he undoubtedly refers only to certain phases of the psychosis.

On the other hand, Eissler (3) sees the superego as regressing to such a friendly level that it permits the patient to employ neologism as if it were a universal language. In certain passages of Nunberg's truly classical papers (18), the dissolution of the superego in schizophrenia is postulated. This is seen as a concomitant of the schizophrenic withdrawal of libido during which the objects which entered into the erection of the superego are more or less lost (18). Alexander (1), as I previously mentioned, denies a place to the superego as a functioning part of the mental apparatus of the schizophrenic and places principal emphasis on the conflict with reality and on the contradictory instinctual impulses.

So much for the theoretical differences in this narrow area. If we consider treatment recommendations, much less reconcilable statements appear. Fromm-Reichmann (13), long an advocate of gentle, friendly permissiveness, objects to Kurt Eissler's alleged remarks that the therapy of schizophrenia is effective solely by virtue of the love offered the patient. Kurt Eissler (3), as I read his remarks, actually made a rather opposite statement. He pointed to love and patience as the two prevailing emotions in Fromm-Reichmann's technique and said that he doubted whether it was right to build the psychotherapy of schizophrenia on these two emotions. He indicated that love may drive the schizophrenic into deeper withdrawal if it increases guilt feelings, and patience may hurt the schizophrenic who senses in it the quality of a defence against impatience. Eissler advocated a matter-of-fact, objective attitude, but realistically acknowledged that the schizophrenic's treatment requires an emotional language and must be conducted in an emotional medium.

Federn (5), as we have seen, went to considerable lengths to foster positive and avoid negative transference. Fisher (9) employs ' psychic shock treatments ' in which he interprets ruthlessly, often being disparaging and overwhelming, sparing the patient's feelings not at all. Fromm-Reichmann (13, 14) has, if anything, been even more cautious than Federn. When, several years ago, she wished to qualify the generalized prescription of permissiveness and acceptance, she merely added ' respect and understanding according to the patient's chronological age '. Rosen's (21) method of direct analytic therapy [3] certainly offers a challenge to such an approach, shows no special concern about developing negative transference, and focuses largely on direct and immediate interpretation. Hoch (21), in so far as he trusts in the efficacy of psychotherapy for schizophrenia, advocates a ' continuous drip method containing affection and protection '. Winnicott (25) believes that hate is actively sought by some

[3] I have purposely avoided extensive reference to the work of Dr. Rosen, whose methods deserve the most careful attention. I have been privileged to observe his treatment of patients on many occasions and have received a large share of my initial interest in the therapy of schizophrenia from my contacts with him. His extensive and earnest research is in the process of development. Until he is farther along in conceptualizing his methods and his views on schizophrenia, my own impressions had best be reserved for those personal exchanges between us which have been such a source of pleasure to me.

patients, especially psychotics, and what then must be supplied is hate that is objective. Schwing (23) leaves no doubt that she considers love as the main highway to reach the schizophrenic, while Alexander (1) simply advocates fostering the positive transference.

Such is the state of affairs in our theory and practice. Of course some of these differences are more apparent than real and are matters of terminology. Some are referable to the varying times at which authors presented their thinking. There is no doubt, too, that some of these conflicts derive their conspicuous character from the extreme condensation I have made of the authors' views. Nevertheless, sharp differences in theory and practice do actually exist, and it is of the utmost importance to clarify our thinking on these issues.

At the moment I cannot carry the discussion beyond the presentation of my own views and a statement of the questions as I see them. It is my belief that these views have very practical consequences both for the individual psychotherapy of schizophrenic patients and for their hospital management. It is also my conviction that a considerable body of clinical data already exists in the literature which, when abstracted from the theoretical interpretations in which they are embedded, will lend credence to these views. Such problems I hope to take up in a subsequent report. My present purpose is served if I have stated the issues clearly enough to invite a new examination of the clinical data in the light of the structural conflict in schizophrenia.

(Received January 10, 1951)

BIBLIOGRAPHY

(1) Alexander, Franz (1931). 'Schizophrenic psychoses: Critical considerations of the psychoanalytic treatment', *Arch. Neurol. Psychiat.*, **26.**

(2) Brill, A. A. (1929). 'Unconscious insight', *Int. J. Psycho-anal.*, **10.**

(3) Eissler, Kurt (1943). 'Limitations to the psychotherapy of schizophrenia', *Psychiatry*, **6.**

(4) Erickson, Milton H., and Kubie, Lawrence S. (1941). 'The successful treatment of a case of acute hysterical depression by a return under hypnosis to a critical phase of childhood', *Psychoanal. Quart.*, **10.**

(5) Federn, Paul (1943). 'Psycho-analysis of psychoses, I. Errors and how to avoid them', *Psychiat. Quart.*, **17.**

(6) —— (1943). 'Psycho-analysis of psychoses, III. The psychoanalytic process', *ibid.*, **17.**

(7) —— (April, 1947). 'Principles of psychotherapy in latent schizophrenia', *Amer. J. Psychotherapy*, **1,** No. 2.

(8) Fenichel, Otto (1941). 'Problems of Psychoanalytic Technique', New York, Psychoanal. Quart. Inc.

(9) Fisher, V. E. (April, 1944). 'Psychic shock treatment for early schizophrenia', *Amer. J. Orthopsychiat.*, **14.**

(10) Freud, Anna (1949). Reported in Jekels, Ludwig, and Bergler, Edmund. 'Transference and love', *Psychoanal. Quart.*, **18.**

(11) Freud, Sigmund. 'Neurosis and Psychosis', *Collected Papers*, **2.**

(12) —— (1921). *Group Psychology and the Analysis of the Ego.* New York, Boni and Liveright.

(13) Fromm-Reichmann, Frieda (August, 1948). 'Notes on the development of treatment of schizophrenics by psychoanalytic psychotherapy', *Psychiatry*, **2,** No. 3.

(14) —— (October, 1939). 'Transference problems in schizophrenics', *Psychiat. Quart.*, **8,** No. 4.

(15) Hayward, Malcolm L. (1949). 'Direct interpretation in the treatment of a case of schizophrenia', *Psychiat. Quart.*, **23,** No. 4.

(16) Knight, Robert (November, 1946). 'Psychotherapy of an adolescent catatonic schizophrenia with mutism', *Psychiatry*, **9,** No. 4.

(17) Menninger, Karl A. (1940). 'Psychoanalytic psychiatry: Theory and practice', *Bull. Menninger Clin.*, **4.**

(18) Nunberg, Herman (1948). 'Practice and Theory of Psychoanalysis', New York, Nervous and Mental Disease Monographs, No. 74.

(19) Pious, William L. (September, 1949). 'The pathogenic process in schizophrenia', *Bull. Menninger Clin.*, **13,** No. 5.

(20) Rado, Sandor (1925). 'The economic principle in psycho-analytic technique', *Int. J. Psycho-anal.*, **6.**

(21) Rosen, John M. (January, 1947). 'The treatment of schizophrenic psychosis by direct analytic therapy', *Psychiat. Quart.*, **21.**

(22) Schilder, Paul (1939). 'The psychology of schizophrenia', *Psychoanal. Rev.*, **26.**

(23) Schwing, Gertrud (1940). *Ein Weg zur Seele des Geisteskranken.* Zürich: Rascher Verlag.

(24) Strachey, James (1934). 'The nature of the therapeutic action of psycho-analysis', *Int. J. Psycho-anal.*, **15.**

(25) Winnicott, D. W. (1949). 'Hate in the counter-transference', *Int. J. Psycho-anal.*, **30.**

THE STRUCTURE OF PARANOID IDEAS

A CRITICAL SURVEY OF VARIOUS THEORIES [1]

By ROBERT WAELDER, PHILADELPHIA

Many psycho-analysts will agree that the structure and formation of paranoid ideas has not as yet been fully understood. Psycho-analysis came into being through the study of classical neurosis, and we are still more familiar with this than with any other subject. In other areas of psychopathology our knowledge is more fragmentary and we can not as yet tell the whole story.

Paranoid ideas present a major challenge to psychological theory. This is not due to the fact that paranoiacs adhere to erroneous ideas. We all entertain erroneous concepts about many things. Our misconceptions may partly be due to intellectual factors, i.e. to our ignorance, to the fact that we can approach the new and unfamiliar only in terms of the old and familiar, and to insufficient power of abstraction, of emancipating ourselves from previous impressions; and partly to emotional factors, to what William James called the will to believe.[2]

But most people, i.e. those who are not paranoid, can modify their beliefs under the impact of experience. As a rule, we do not part with our beliefs immediately when experience testifies against them, but we yield to repeated evidence.

Paranoid ideas, however, cannot be corrected by experience. Kraepelin has therefore defined delusions as ' erroneous judgements not subject to correction by experience ' (15).

This is a challenge to our theory because it seems to contradict a law of psychology, both human and animal, namely, that one learns through experience. Why, or under what conditions, are misconceptions of reality not subject to the corrective influence of experience? Under what conditions are people unable to learn? [3] A theory of delusions will have to account for their inaccessibility to influence. No theory that fails in this point could be held satisfactory.

I. Survey of Various Psycho-analytic Concepts

Narcissism and the maldistribution of libido

The first attempt to explain delusions was made by Karl Abraham (1) in a paper written under the influence of Freud and in Freud's paper on narcissism (5). As is generally known, Freud and Abraham suggested explaining delusions of grandeur by a withdrawal of libido from the object world and its concentration on the ego. Libido has thus become narcissistic; since the sexual object is always overvalued, the ego, now the exclusive object for the libido, is overestimated and magnified.

This is an explanation in terms of libidinal cathexes. It is an attempt to explain megalomania by reducing it to a familiar condition, viz. to the overvaluation of an object in the state of infatuation.

It suggests that any concentration of libido is detrimental to the sense of reality, and that a more equal distribution of cathexes may be the best condition for a balanced judgement of reality. Since the concept of a destructive instinct has been added to our instinct theory, this early hypothesis can be generalized. We

[1] The main points of this article were presented to the Philadelphia Psychoanalytic Society on December 16, 1948.

[2] I have discussed these factors on another occasion (18).

[3] The problem of paranoia is of great interest from the point of view of applied psycho-analysis, too. Many systems of thought which have profoundly influenced the course of history have been more or less akin to paranoid systems. One may even say that history is, to a large extent, the outcome of two forces, viz., on the one hand the process of learning from experience, the struggle for a better adjustment to, or a better mastery of, reality, both natural and man-made, and on the other hand the ever-continuing rise of paranoid structures. The struggle between democracy and totalitarianism is, to some extent, a struggle between ' ordinary ' people, with all their ignorance and unwisdom, who are capable of learning through experience if given time, and paranoiacs or people infected by paranoid ideas. It is a fight in which all the initial advantages are with the paranoiacs, but which they are bound to lose, because of their lack of elasticity, unless they can turn initial advantages into complete victory.

may say that not only the concentration of erotic drives upon one object, be it an outside object or our own ego, but also any concentration of destructive forces upon others or upon ourselves is bound to distort or to destroy the sense of reality. The attitude which groups with strong cohesion show towards outsiders offers an example of the former, the self-debasement of the melancholic of the latter.

Thus, the concentration both of erotic and aggressive drives upon an object is detrimental to the sense of reality and the most favourable condition for a balanced judgement seems to be a wide and not too unequal distribution both of libido and destruction. The fact that, as a rule, obsessional neurotics with their proverbial ambivalence seem to retain, even in conditions of grave illness, their ability of judging reality fairly correctly, dovetails well with these generalizations.

The hypothesis should also supply us with an explanation of the fact that delusions are inaccessible to influence. If the megalomaniac's libido is concentrated on his ego, and if he therefore overvalues himself grossly, corrective experience cannot reach him because he has no free libido to take it in and weigh it properly. In this way, the hypothesis makes judgement, and even perception, a function of cathexis.

This, however, meets with some difficulties. First, there is a theoretical difficulty; how does the idea that judgement is a function of libidinal cathexis fit in with the anaclitic type of object choice? If the libido follows the self-preservative instincts, i.e. if we love what is useful to us, there must be a perception of facts and an appreciation of their utility before there is any libidinal cathexis.

There are clinical difficulties, too. We know of cases of circumscribed paranoid systems in persons who have not withdrawn their libido from outside objects; they may have strong, sometimes warm, object relationships and they often succeed in defending and protecting these relationships against the threatening intrusion of their paranoid ideas. It would be difficult to explain, in such cases, the breakdown of reality-testing as a consequence of a libidinal retreat which has not taken place on any large scale. One may point out that object-libido was withdrawn in a certain area and that this limited withdrawal has undone the reality-testing, but it would be very difficult to work this idea out in concrete terms.[4]

Furthermore, it seems questionable whether the delusion of a man who claims to be Jesus Christ is really of the same quality as the overvaluation shown, e.g. by a mother for her child. Mothers or lovers can be conspicuously blind to the flaws of their beloved though these may be patent to everybody else. But they do not go as far as paranoiacs; there is yet a vast difference between their affectionate misjudgements, however stubbornly defended, and those of real paranoia. It seems more correct to say that the misjudgements due to love and hatred are still on the fringe of ' normality ' while paranoid ideas have crossed that line.

Projection

According to another hypothesis, delusions are a product of projection. An inner process which has become subject to this mechanism is perceived as coming from outside.

The hypothesis may go a long way towards an understanding of paranoid ideas,[5] but the

[4] The fact that patients suffering from paranoia have sometimes preserved good object relationships seems to me to invalidate those theories which consider the complete loss of object cathexis as a prerequisite of *all* delusion formation.

[5] Projection is a convenient concept of psycho-analytic explanation and one may wonder whether it has not often been applied to situations in which a more detailed examination may have led to a different evaluation.

For instance: A middle-aged man of my observation had ideas of reference. It was not a case of paranoia but an obsessional neurosis with paranoid tendencies. His paranoid constructions might easily have been interpreted as projections—this, indeed, was occasionally suggested by the patient on the basis of his reading knowledge. But closer examination seemed to favour another view. The patient lived in perpetual expectation of attack or insult and his attention was pitched high to detect microscopic signs of hostility or disparagement in others. The sooner he noticed approaching danger, the better would he be able to prepare himself. In the lingo of his analysis we called it his ' radar '. In the background of this patient's history was a vulgar father, with incessant verbal abuse and occasional serious physical threats. The patient's passive homosexual trends which were amply manifested would increase the danger; he knew that, if attacked, he would be strongly tempted to surrender and had therefore all the more reason to safeguard himself against attack.

The same person showed another mechanism in a paranoid idea which occurred in the transference. Once during an hour he thought that I suspected him of theft. The examination of the circumstances showed convincingly that in the immediately preceding moment he had expected blame in a matter in which he was far from guiltless. The sudden idea that he was to be accused of a theft of which he was obviously innocent was not a projection of an impulse but an attempt at rapidly changing the scene of action, away from his actual guilt and from the danger of being called to task for it, to another subject in which he would feel on safe ground. It was as if he would say: I have no more done what you blame me for than I have stolen your money.

A young man with slight paranoid ideas attributes to

concept of projection needs further clarification. Is projection meant to be an elementary mechanism, one of the fundamental and irreducible responses to challenge, or it is a complex mechanism?

First, we should distinguish between two cases of projection which seem to require independent consideration, viz. the projection of a superego voice and the projection of an instinctual drive. A girl who believes that people call her names, accuse her of being a prostitute, etc., has projected a critical voice of her superego. A person who attributes his own aggressive designs or temptations to others projects an id impulse.

The first case is easily comprehensible. The superego is the result of the internalization of external commands and prohibitions. Once the voice of the superego has been projected, an earlier condition has been restored. Projection of the superego is a regressive process.

No such explanation, however, applies to the second case, viz. the projection of instinctual drives. How does it happen that one can experience one's own instinctual urge as belonging to another person?

Freud suggested in different contexts two different answers to this question; they may be called *the biological and the psychological concepts of projection.* According to the former (6), projection is an attempt to treat an inner stimulus as though it came from outside so as to be able to apply to it the defences which have proved useful in dealing with external stimuli.

According to this concept, projection is an elementary response to painful stimuli. But this assumption is not free from difficulties. We may wonder, first of all, why projection thus conceived is more readily applicable to some stimuli (such as instinctual drives) rather than to others (such as pain). Furthermore, a mechanism as elementary as this must be expected to manifest itself very early in life, as one of the most primitive responses. This conclusion has indeed been drawn by Melanie Klein (14) and her collaborators, but it seems to me that conclusive evidence for these early manifestations is still wanting.

Finally, the hypothesis does not seem to explain why the result of the mechanism should not be subject to corrective experience. Assuming that we try to treat inner stimuli as though they were outside, why is it that cumulative experience of outside events which are not in accordance with our projections does not gradually unteach us such deceptions?

A ' psychological ' concept of projection was introduced by Freud in a clinical paper (7). In discussing ' projected jealousy ' Freud says:

> ' The jealousy of the second layer, the *projected,* is derived in both men and women either from their own actual unfaithfulness in real life or from impulses towards it which have succumbed to repression. It is a matter of everyday experience that fidelity, especially that degree of it required in marriage, is only maintained in the face of continual temptation. Anyone who denies this in himself will nevertheless be impelled so strongly in the direction of infidelity that he will be glad enough to make use of an unconscious mechanism as an alleviation. This relief—more, absolution by his conscience—he achieves when he projects his own impulses to infidelity on to the partner to whom he owes faith. This weighty motive can then make use of the material at hand (perception-material) by which the unconscious impulses of the partner are likewise betrayed, and the person can justify himself with the reflection that the other is probably not much better than he is himself.'

This idea gives a different picture of projection. An urge—of infidelity—is denied; it keeps up its pressure and causes an uneasy conscience. In order to free himself from a sore conscience, the person seizes upon observations which betray similar temptations in his partner, and attributes his infidelity to him. In this context, projection, far from being an elementary response, appears as a highly complex mechanism; its ingredients are the denial of one's own urges, the desire to shift the blame, and the exaggeration of traits actually observed.

A *syntactic* characteristic of the projection mechanism calls for our attention. The outcome of projection has the form of an assertion or assumes this form whenever verbalized:

---

his partner the criticism which he keenly feels of himself. This seems to be a case of projection of the superego. But closer examination suggested that there was a more complicated process at work. He is a dreamer who easily forgets about reality and becomes absorbed in his phantasies; he tries to get and to keep up contact with others but loses it constantly. Whenever he loses contact he is afraid that he might suddenly be attacked and thus be taken off guard. In his attempts to establish contact which does not come to him naturally, he tries to identify himself with others and to find out and produce in himself ' how they feel '. Trying to get inside another person in his effort to establish contact, he must attribute his own ideas about himself to the ' host ' and see himself with his own eyes from within the host's body. The process is similar to the identifications in adolescence which Anna Freud described as attempted restitutions for the loss of objects (3).

'They have aggressive designs against me', 'He wants to seduce me', etc. This is not true of other defence mechanisms such as, e.g. repression, reaction formation, undoing, etc. Defence mechanisms applied against instincts may make the individual unaware of his strivings, or (and) cut them off from access to the motor system, change their aim or object, or lead to various forms of countercathexis. But a statement, a claim, is an unusual outcome. There seems to be one other defence mechanism only for which this holds true, viz. denial. This fact seems to suggest, in accordance with Freud's above-quoted analysis of projection, that projection is a form of denial, i.e. denial with a specific countercathexis. It is denial to say to a fact: it is not true. We may disclaim it with or without adding our own version of what we claim to be the truth. We call it projection if we fortify the denial of our own impulses—or guilt—by blaming somebody else. A two-year-old child may disclaim responsibility for having wetted the bed; if he claims that the dog or the teddy bear is the sinner he has made a projection. In fact, he has merely strengthened his denial (I have not done it) by a particular form of countercathexis (he has done it).

The break with reality

Another approach was outlined by Freud in his paper on neurosis and psychosis (8). The paper deals with psychosis as a disease, not with delusions as symptoms, but its concepts are applicable to the latter, too. Psychosis, Freud suggests, is the outcome of a conflict between the ego and the outside world. While in psychoneurosis the ego sides with reality and turns against the id, the ego in psychosis allows itself to be swept away by the id and is thus separated from reality. Emancipated from reality, the ego creates for itself a new world which is set up in accordance with the desires of the id. Freud raises the question of what mechanisms the ego uses in untying itself from reality and suggests that this mechanism, like repression, consists of a withdrawal of libidinal cathexis.

Denial and phantasy

Later contributions, however, suggest that the mechanism in question is *denial*.

Anna Freud (3) discusses the role of denial (of a frustrating reality) in childhood as a means of avoiding anxiety, and adds this about psychosis:

'In certain acute psychotic confusional states the patient's ego behaves towards reality in precisely this way. Under the influence of a shock, such as the sudden loss of a love-object, it denies the facts and substitutes for the unbearable reality some agreeable delusion.'

Freud, too, had used the concept of denial to explain an acute hallucinatory condition. He used the example of a woman who, in an acute state of confusion after the loss of her child, carried a piece of wood along, claiming that her child was alive and that the fetish in her hands was her child. Freud pointed out that the fact that the patient hangs on to her phantasy child and does not permit it to be separated from her for a moment, proves that a continuous effort of denial must be extended to ward off the realization of the truth which is constantly knocking at the door.

However, the idea of denial, without its name and in a different frame of reference, had been used by Freud much earlier (4) in his formulæ for the four types of paranoia: delusions of persecution, delusional jealousy, erotomania, megalomania. All these formulæ begin in this way: 'I do not love him'; this is followed by contradicting claims which support the denial (such as, e.g. 'I hate him', or 'I love her', etc.), i.e. various types of countercathexis. In these earlier considerations, denial was assumed to be applied not to a frustrating reality but to an instinctual drive.

Restitution

Delusions have also been explained as attempted restitutions (9). The patient who has lost the world through withdrawal of his libido tries to rebuild it. 'The delusion formation which we take to be a pathological product is in reality an attempt at recovery, a process of reconstruction' (Freud, 4). This conception is of great, perhaps crucial importance for an understanding of psychosis. Yet it is questionable how much it can help us to understand the content of a particular paranoid idea.[6] And in which way restitution is connected with the paranoid mechanism remains unexplained—unless we assume that restitution operates through projection.

[6] The above survey of psycho-analytic concepts having been written, for the most part, in 1948, important ideas on this subject by M. Katan which appeared in print in the last two years (13a, 13b, 13c) have not been included in the reviewed lines of approach.

The historical truth

In one of his latest papers (11) Freud introduced a further idea about delusions. Delusions may contain an element of truth, albeit distorted, and it may be due to this content of truth that people stubbornly adhere to their delusions and cannot be dissuaded from them. The old analytic rule of thumb that the patient is always right, in a sense, and that it is up to the analyst to discover in what sense he is right, may thus apply to paranoia, too.[7]

Freud did not arrive at this idea under the impact of clinical observation, but it suggested itself to him in the course of his historical and prehistorical studies (12). The simplest example is Freud's interpretation of the myth of the chosen people.

The belief of the Hebrews that they were the chosen people may be called a kind of collective delusion. It is important to realize that it is not simply a case of parochial arrogance and provincialism such as is indeed common to most, perhaps all, civilized people. It is more specific than this; the Hebrews did not merely claim to be equipped with more excellent qualities than other nations. They claimed that God had actually chosen them from among all the nations, this child among all His children, to be His people, and had entered into an alliance with them.

Freud, in his reconstruction of early Hebrew history (12), suggested an explanation for this secular delusion, namely, that it is a poetic elaboration of the historical truth. The Hebrews were indeed chosen, according to Freud, not by God but by an Egyptian lord and follower of Akhnaton who had condescended from his rank and had chosen, arbitrarily, the Hebrew people to be the worshippers of his God, Aton, after the Aton cult had been swept away by reaction in Egypt. The Hebrews, according to this reconstruction, had actually gone through the experience of being chosen by a mighty man and rescued from Egyptian servitude—an experience which was bound to make an indelible impression upon a humble and as yet unhistoric tribe. It was due to the lasting impact of a real experience early in the history of their nationhood that the Hebrews clung so stubbornly to their idea of divine selection, regardless of all their subsequent misfortunes.

Another example is furnished by Freud's idea about monotheism and the Christian doctrine of the sacrificial death of the son of God. The historical truth of the powerful primeval father who was killed by his rebellious sons constantly pressed to return to consciousness. Throughout the ages of polytheism people have repeatedly come close to the monotheistic conception—a symbolic expression of the historical truth, in Freud's hypothesis—until eventually the break-through was completed and monotheism was established. The redemption of mankind through the sacrifice of Jesus represents, according to Freud, the break-through of another part of the historical truth, i.e. of the crime of parricide which the sons time and again had committed in primeval ages, which was repeated in historical times—e.g. in the murder of Moses—and is repeated, on a psychological level, in the childhood of each generation. The son of God took the guilt of all upon himself and atoned for the deed with his life.

Once Freud had arrived at his hypothesis in the course of non-clinical pursuits, he searched in his memories of earlier clinical experience for material to which it might apply. The following two cases, observed by Freud at a much earlier time, were now reconsidered in the light of the new concepts.[8]

There was a case of a woman with delusional jealousy. Without basis in reality, she suspected her husband of illicit relationships with a number of elderly women who, in fact, were most unlikely to attract the man's attention. Analytic material suggested that these women resembled a nursemaid of her childhood. Furthermore, analytic material had led to the suspicion that the patient's father had once had a sexual relationship with this nursemaid. Looked at in retrospect from the point of view of the new hypothesis, this material permits the following interpretation: the patient's pathological jealousy was the consequence of a break-through of the real experience of her father's affair with the nursemaid. This intensely felt content of truth makes the delusional idea inaccessible to influence.

The other case was one of inventor's delusion. Each time the patient worked at a new 'invention' he expected enthusiastic welcome for his contribution; each time there was disillusion

[7] We may remember that Helene Deutsch had shown (2) that the stories of pathological liars contain an element of truth.

[8] Oral communication.

and resentment. There seemed to have been a childhood situation in which the boy, after discovering masturbation, hastened to communicate his find, in expectation of praise. His claim, as an adult, 'I have made a discovery (or an invention)' would in this way have a nucleus of truth.

An Idea of Tausk's

Another hypothesis about the paranoid mechanism was intimated in a posthumously published article by Tausk (17).

Tausk relates a piece of psychopathology of everyday life. Time and place are Central Europe before the First World War. In order to evaluate the story it is necessary to remember that the Norwegian playwright, Hendryk Ibsen, enjoyed a tremendous popularity on the Continent. His works and personality were discussed everywhere and landmarks of his career, e.g. the fact that he had once been a pharmacist, were matters of common knowledge.

Tausk reports a scene which occurred during a conversation on dramatic literature with a certain Mr. B., a writer and admirer of the Norwegian poet. It happened in the studio of a mutual friend. The place was filled with many objects of art; among them was a bust of Ibsen. Everything in the studio had long been familiar to Mr. B.

Mr. B. suddenly stopped before Ibsen's bust with an expression of bewilderment and asked: Who is this man? I seem to know him.

Tausk knew Mr. B.'s personal circumstances. Mr. B. had recently been involved in a love affair with the wife of a pharmacist and the irate husband had threatened to beat him up. Mr. B. had used the threat to terminate a relationship of which he had already grown tired. It was an unsavoury affair. Tausk made a kind of short-cut interpretation and merely said: This is the pharmacist, and Mr. B., who realized at once what it was all about, did not look too happy.

The implications of Tausk's remark are obvious. Ibsen was a pharmacist, as was the man to whom Mr. B. owed an embarrassing experience. He did not want to know Ibsen any longer as the poet might remind him of the pharmacist of his private life. In order to eliminate the offensive pharmacist he tries to eliminate whatever may remind him of him. Then follows the return of the repressed; the statue of Ibsen forces itself on his attention. But owing to the withdrawal of libido, the returning object has changed its character; instead of being familiar it appears strange. In Tausk's own words:

> 'Why did Mr. B. have to halt precisely before Ibsen's bust since there was nothing unusual about it to attract his attention? Now, actually, there was something unusual about the bust; it had become strange to him and therefore could not but attract his attention in this studio in which every object had long been familiar to him. The repressed Ibsen returned in this form as a messenger from the repressed pharmacist. An aspect of the *paranoid mechanism* is clearly revealed here. Persons from whom the paranoiac has withdrawn his libido reappear to him as strangers.'

It must be emphasized, for better or worse, that Tausk deduced this idea about the paranoid mechanism from the discussion of a case which had nothing to do with paranoia.

II. Possibilities of an Integrated Theory

The wealth of constructive ideas in this area is impressive. Surveying the field, we see, on the one hand, concepts about a break with, or a withdrawal from, or a denial of, reality; on the other hand, concepts of restitution, of the return of the repressed (Tausk), and of a historical truth that forces itself into recognition.

Could it be that all these concepts describe various aspects of the total picture, that the clue which permits the jigsaw to be put together is the mechanism of *denial*, and that paranoid ideas are as much the *results of unsuccessful denial* as psychoneurotic symptoms have long been known to be the results of unsuccessful repression? [9]

The mechanism involved in the motion away from reality seems to be denial. As far as the hypothesis of historical truth is concerned, it is quite likely, and is actually assumed by Freud, that the facts which force themselves upon the patient are facts which he had denied when they occurred. At least one, possibly two, of Freud's examples fit in with this assumption. The woman with delusional jealousy may well have tried to deny her father's relation with the nursemaid. The killing of the primeval father, or the repetition of the crime

[9] or of a limited number of other defence mechanisms as, e.g. isolation.

in the murder of Moses, was probably denied by the perpetrators.[10]

What was denied in the above-mentioned examples was a real occurrence—the murder of the primeval father or the father's relationship with the nursemaid. Denial is usually looked upon as a mechanism to deal with external facts, with danger, anxiety, grief or guilt, but not with instincts. Yet the existence of projection—which appeared as a form of denial with a particular countercathexis—suggests that denial may be a method of dealing with instinctual drives also.

A unified theory may be contemplated approximately along these lines: something is denied—we leave it open whether it is a frustrating event or an instinctual drive. Phantasies are used to support the denial—countercathexis. (This covers the hypothesis of denial of reality and its substitution by phantasy.) The results do not constitute paranoid delusions though on occasions they may approximate to them when great intensities are involved.[11]

Then, there may be a return of the disclaimed in distorted form. (This covers the theory of restitution, the theory of historical truth, and whatever may be useful in Tausk's concept.) The return of the disclaimed must have the form of a claim. The knowledge of its essential truth makes it inaccessible to influence. This would be the paranoid product proper. The returning material may, or may not, unite with the countercathexis which served to uphold the denial, to form a symptom held from two sides (compromise-formation).

Projection is denial with a special countercathexis. Since the mechanism consists in disclaiming, the countercathexis has the form of a claim.

But there is one more connection to be considered. Not only has the countercathexis the same formal structure which the defensive operation had. The return of the warded-off material, too, is bound to have the same formal characteristics. This relation, which may be of general significance, may be called the *isomorphism* of symptom and defence mechanism. If the defence was denial, the return of the disclaimed has the form of a claim.

The delusion of persecution

The hypothesis may be tested by applying it to the delusion of persecution. The point of departure is, as in psychoneurosis, a pathogenic conflict, i.e. a conflict which the ego was unable to settle to its satisfaction. In this case, it was a conflict over a homosexual temptation. The defence mechanism is denial.[12] The fact that one loves a person of the same sex can be denied in different ways. One may say: 'No, it is not true, I do not love him'; or one may say, 'No, it is not true, I am not a homosexual'. Both ways of denying are used; they have different consequences.

Countercathexis is applied to keep the defence effective. The countercathexis for the first form of denial may be: 'Rather, I don't care for

---

[10] It seems to me that there is inherent in Freud's thinking the assumption that reality, or truth, however forcefully denied, has a tendency to come back and to present its bill, and that there will be no peace until it has been recognized. The indestructible power of truth (*magna est veritas et prævalebit*) is an analogy and counterpart of the indestructible power of the instincts (*naturam expellas furca, tamen usque recurret*). These two assumptions are complementary in Freud's philosophy.

The dynamic behind the instinct is obviously their driving power, and one may ask what dynamic force is responsible for the demands for recognition of reality. This force seems to be *fear*, i.e. fear of being defenceless *vis-à-vis* dangers if we do not watch and recognize reality.

This may be illustrated by an example taken from the analysis of the young dreamer with the labile contacts (cf. footnote 5). He used to complain about 'shock feelings' which he experienced in his body. It turned out that they occurred when he had withdrawn from contact with people into his phantasies and became suddenly aware of his loss of contact. That made him feel panicky because he was defencelessly exposed to surprise attack and could be 'caught with his pants down'. He had to re-establish contact with the utmost speed. It was as if a troop of soldiers, camping in enemy territory, should discover that the sentries had fallen asleep.

In countless instances, the return of reality merely leads to a recognition of the facts as they are, and no pathology occurs. But if powerful resistances are at work, the truth may appear in distorted form. In Freud's words (11):

'In the mechanism of a delusion we stress as a rule only two factors: the turning away from the real world and its forces on the one hand and the influence exercised by wish-fulfilment upon the subject-matter of the delusion on the other. But may it not be that the dynamic process is rather that the turning away from reality is exploited by the upward drive of the repressed in order to force its subject-matter into consciousness, while the *resistances* stirred up by this process and the impulse to *wish-fulfilment share the responsibility for the distortion* and displacement *of what is recollected?* This is after all the familiar mechanism of dreams, which intuition has equated with madness from time immemorial.'

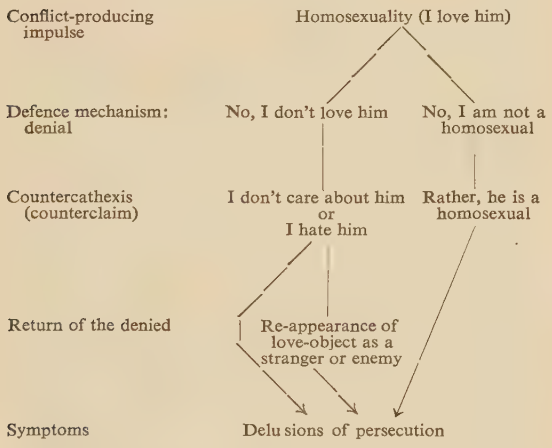
[11] The existence of neurotic strata in psychosis has been emphasized by M. Katan (13, 13b, 13c).

[12] This does not exclude the possibility that other mechanisms are used, too; it merely suggests that it is denial that starts the development along the dangerous road.

him', or: 'Rather, I hate him'. The countercathexis for the second form of denial may be: 'Rather, he is a homosexual'. In this way, we already have the outline for a possible paranoid system. But there is as yet no real paranoia; the warding-off of an urge by denying its existence and clinging to contradicting claims may sometimes look similar to, without really being, paranoia.

But there may be the return of the denied. This possibility seems to apply only to the first of the two forms of denial discussed. The homosexual object, love for whom had been denied, may return. At this point, Tausk's suggestion can prove useful. The beloved returns from the shadow world with changed appearances; from a familiar and beloved object he has turned into a stranger. Strangeness, in the unconscious, is close to hostility. All these elements merge in the final paranoid system. Just as the hysterical symptom may be a 'compromise between the need for gratification and the need for punishment—a frontier station under joint occupation' (Freud, 9), so may the idea of persecution be an expression both of the phantasies which were substituted for reality and of the warded-off drives, the object of which has returned with changed features.

DIAGRAM


Conflict-producing impulse
Homosexuality (I love him)
Defence mechanism: denial
No, I don't love him
No, I am not a homosexual
Countercathexis (counterclaim)
I don't care about him or I hate him
Rather, he is a homosexual
Return of the denied
Re-appearance of love-object as a stranger or enemy
Symptoms
Delusions of persecution

The denial of instinctual drives

The suggested explanation of ideas of persecution depends on the assumption that the instinctual drives can be denied and that this process is characteristically different from repression and has different consequences.

This assumption has been challenged; it has been argued [13] that, in fact, denial of instinctual drives is but another name for their repression and must consist, like the latter, in a withdrawal of preconscious cathexis.

When speaking of 'repression', we almost always think of unsuccessful repression. Yet unsuccessful repression is merely the result of an effort that had aimed at more and had failed; there are probably many cases of successful repression for each case of an unsuccessful one, but they escape our attention precisely because they were successful. In Freud's words (10):

> 'If by means of a signal of distress the ego attains its object of completely suppressing the instinctual impulse, we have no intimation of how this happens. We learn something about it only from the cases in which repression is more or less unsuccessful.'

The difference between denial of an instinctual drive and its (unsuccessful) repression lies, first of all, in the *intent*. The child did not start out to banish the instinctual representation from consciousness; it tried to *conquer* the instinct. The withdrawal of preconscious cathexis is merely what happens if the endeavour that had aimed at a higher objective fails. In the denial of an instinct, however, no such attempt at conquering it has been made. It is as if the ego felt powerless to do anything against the instinct and merely disclaims its existence. Thus, unsuccessful repression is yet a monument of a struggle in which the ego had turned against the instinct. It was in vain, but *in magnis voluisse sat est*. Where great things are at stake, it is enough to have honestly striven—enough, at least, to be protected against psychosis.

Furthermore, the instinct remains closer to consciousness in denial than in repression. The 'psychological concept' of projection is an example to show how the denied instinct remains in the limelight; he who projected his aggressiveness on to others has his mind occupied with aggressiveness, albeit somebody else's.

Denial is betrayed by its countercathexis, i.e. by the noisy counterclaims.

Applications

The hypothesis discussed may help to explain the difference between psychotic and normal

[13] Private discussions.

projection. It is generally known that projection, the mechanism *par excellence* of psychotic delusions, is quite common among neurotic and normal people. Yet no clear criterion of what makes projection a psychotic mechanism has been suggested. According to the hypothesis brought forward in the present article, projection—the denial of one's own drives fortified by blaming somebody else—is not psychotic. When it appears as a 'psychotic projection' it is actually more than projection; it is the forcible, disguised, return of the person, love for whom the patient had denied (and, perhaps, projected). This person may, or may not, be the same person who was used for projections, and this fact may obscure the difference between simple projection, which is subject to correction by repeated experience, and the distorted return of an object which is not.[14]

The hypothesis may also throw some light upon the relation between paranoia and querulosity. These two syndromes seemed always to be closely related, but their kinship was sensed rather than clearly understood. From the point of view of the proposed hypothesis, the paranoiac began with the denial of an instinctual urge. The querulous person, on the other hand, publicly denies his guilt, proclaims his innocence or his grievances, and goes to great lengths in his efforts to persuade others into accepting his claims. Both have therefore a basic attitude in common.

Paranoia and the methods of adaptation

One of the fundamental concepts of psychoanalysis tells us that the instinctual drives of every individual must come into conflict with reality, i.e. with the laws of nature, the aspirations of his fellow-men, and the institutional set-up. The process of adjustment can be alloplastic or autoplastic, and is in fact always a mixture of both in varying proportions. In the alloplastic type of adjustment the individual changes the conditions in the world around him to such a degree that he can satisfy his instinctual drives as they are; in the autoplastic type, he cuts down and alters his instincts until they can be satisfied in the reality as it is. Both methods are 'normal' if they are successful, i.e. if the individual actually succeeds in changing either reality or instincts so that the two can meet. Under such conditions, alloplasticsim leads to the active, aggressive, autoplasticism to the passive, submissive, form of normality. Both methods may have pathological consequences if they are not successful. If the individual cannot change reality sufficiently to suit his needs, the result of the alloplastic approach may be psychopathy or delinquency. If he cannot permanently silence or remould his rebellious instincts, the result of autoplasticism may be psychoneurosis.

But there is a third possibility besides alloplasticism and autoplasticism; in this case no attempt is made to change either reality or instinct—it is as though the ego did not feel equal to either endeavour. Instead, the individual persuades himself that there is no real conflict and denies either the unpleasant facts in the outside world or the operation of his instincts. Whoever applies this method with success becomes a dreamer; perhaps, if favoured by talent, a poet or artist. But if the denial is unsuccessful and if the individual has not been called back to reality by this very failure, the possibility of psychosis emerges. Just as alloplasticism is not as such psychopathic, nor autoplasticism as such neurotic, but each a necessary, though not sufficient, condition for the development of one or the other, so is 'escapism' not as such psychotic, but may become so if the method fails.

The denial of external reality and the denial of instincts require separate consideration. The latter seems to be more dangerous than the former. The return of a denied instinct against resistances strong enough to forestall an undistorted break-through may take the form of a violent, delusional assertion.

Every child uses, at times, all the methods of solution in his conflicts with reality. If one method does not work, another one is resorted to. What prepares the ground for pathological development is probably a quantitative factor and, even more than that, a kind of inflexibility which makes it impossible to shift from one method to another.

Generalizations

If the hypothesis should prove correct some simplifications of our formulations would become possible. Neurotic symptoms are

[14] It is characteristic that projection of one's own aggressive designs, a most common phenomenon, does not seem ever to lead to psychosis.

known to follow this pattern: conflict between instinctual drive and ego—repression (or one of the other mechanisms operative in neurosis) and countercathexis—return of the repressed—compromise formation. Delusion formation would follow the same pattern, with denial taking the place of repression: conflict between id and ego—denial and countercathexis—return of the denied—compromises. The original defence mechanism would determine the form in which the warded-off material returns (isomorphism). It may be that further generalizations are possible and that *all* pathological processes, neurotic, psychotic, psychopathic, have the same basic structure, i.e. conflict—defence and countercathexis—return of the warded-off. The difference between pathological productions would be determined by the nature of the conflict, by the choice of defence mechanisms, the choice of countercathexes (though this choice is limited by the nature of the defence mechanism), and by the conditions under which the warded-off returns (though its form is determined by the defence mechanism).

In this way, the defence mechanism is largely responsible for the form of pathology and the old problem of the choice of neurosis can for the most part be reduced to the problem of the choice of defence mechanism.

Concerning an alphabet of defence mechanisms

By defence mechanisms, in this connection, I mean *elementary defences*. The defence mechanisms which are described in our literature are on a variety of levels. Some may indeed be regarded as elementary responses, others are certainly highly complex composites. Some merely indicate what happens to the instinctual representation, and to the access to the motor system. Others imply a special form of countercathexis (e.g. reaction formation). In others, like regression and sublimation, changes in the aim or the object of the instinct are implied.

A list of known defence mechanisms reads sometimes as if a list of chemical substances should go like this: hydrogen, salt, chlorophyll. It is one of the tasks of our ego psychology to develop an alphabet of defence mechanisms, *a catalogue of elementary responses*.

It may be that the elementary mechanisms of dealing with *instinctual drives* can be arranged in a sequence, according to the greater or lesser *degree of change* they impose upon the instinct. At the head of the list is, of course, successful repression, which, for all we know, has put an end to manifestations of the instinct. It is followed by mechanisms which succeed in changing the aim or object of the instinct such as, among others, regression or displacement. Then there follows unsuccessful repression in which the unconscious cathexis seems to remain unchanged but preconscious cathexis has been withdrawn. Then there is isolation in which not even unawareness has been fully achieved. Finally, in denial—or its most common specimen projection—the ego has not even tried to fight the instinct.

SUMMARY

1. Various attempts at explaining psychoanalytically the formation of paranoid ideas are reviewed. With one exception they do not seem to explain satisfactorily the distinctive characteristic of paranoid ideas, viz. their inaccessibility to influence. The exception is provided by Freud's late hypothesis that the adherence to a delusional idea is due to its intrinsic, though distorted, content of truth.

2. There are three possible solutions to the conflicts between individual instinctual equipment and reality: an equilibrium can be established by changing reality (alloplasticism) or by changing the instinct (autoplasticism) or by changing neither but denying one or the other. These methods lead, wherever successful, to various types of normality, i.e. a dominating type, a submissive type, and a type with a rich phantasy life. When unsuccessful, they provide the breeding ground for psychopathy, psychoneurosis, and paranoia respectively.

3. Furthermore, it is suggested that if warded-off instinctual drives make their come-back, the return has the same form as the defence mechanism had; they return, as it were, through the same door through which they were ousted (isomorphism). If the defence mechanism had the form of denial, the return must have the form of an assertion. One type of paranoid ideas at least, the delusion of persecution, may be the result of an (incomplete) return of a denied instinct.

[Received October 16, 1950]

BIBLIOGRAPHY

(1) ABRAHAM, KARL (London, 1927). 'The Psychosexual Differences of Hysteria and Dementia Præcox', *Selected Papers.*

(2) DEUTSCH, HELENE (1922). 'Über die pathologische Lüge (Pseudologia phantastica)', *Internationale Z. f. Psychoanal.*, **8.**

(3) FREUD, ANNA (London, 1937). *The Ego and the Mechanisms of Defence.*

(4) FREUD, SIGMUND. 'Psychoanalytic Notes upon an Autobiographical Account of a Case of Paranoia', *Collected Papers*, **3.**

(5) —— 'On Narcissism: an Introduction', *ibid.*, **4.**

(6) —— (London, 1922). *Beyond the Pleasure Principle.*

(7) —— 'Certain Neurotic Mechanisms in Jealousy, Paranoia and Homosexuality', *Collected Papers*, **2.**

(8) —— 'Neurosis and Psychosis', *ibid.*

(9) —— 'The Loss of Reality in Neurosis and Psychosis', *ibid.*

(10) —— (New York, 1936). *The Problem of Anxiety.*

(11) —— 'Constructions in Analysis'. *Collected Papers*, **5.**

(12) —— (New York, 1939). *Moses and Monotheism.*

(13) KATAN, MAURITS (Leiden, 1946). *De Grondbeginselen van de waanforming.*

(13a) —— (1949). 'Schreber's Delusion of the End of the World', *Psychoanal. Quart.*, **18.**

(13b) —— (1950). 'Schreber's Hallucinations about the "Little Men"', *Int. J. Psycho.-Anal.*

(13c) —— (1950). 'Structural Aspects of a Case of Schizophrenia', *Psychoanalytic Study of the Child*, **5.**

(14) KLEIN, MELANIE (London, 1948). *Contributions to Psycho-analysis.*

(15) KRAEPELIN, EMIL (Leipzig, 1915). *Klinische Psychiatrie.*

(16) NUNBERG, HERMANN (Berne-Berlin, 1932). *Allgemeine Neurosenlehre auf psychoanalytischer Grundlage.*

(17) TAUSK, VICTOR (1934). 'Ibsen the Druggist', *Psa. Quarterly*, **3.**

(18) WAELDER, ROBERT (1949). 'Notes on Prejudice', *Vassar Alumnæ Magazine*, **34.**

A CONTRIBUTION TO THE STUDY OF THE DREAM SCREEN

By CHARLES RYCROFT, London

I. Introduction

In this paper I wish to report an example of a dream without visual content of the type described by Lewin in his paper, 'Sleep, the Mouth and the Dream Screen' (1946), and to make some suggestions as to the clinical and theoretical significance of such dreams.

In his second paper on the dream screen Lewin (1948) writes: The dream screen is 'defined as the blank background upon which the dream picture appears to be projected. The term was suggested by the motion picture, because, like its analogue in the cinema, the dream screen is either not noted by the dreaming spectator, or it is ignored due to the interest in the pictures and action that appear on it. However in certain circumstances the screen plays a rôle of its own and becomes perceptible.' . . . Like other formal elements in dreams the screen has a meaning in itself. It 'represents the idea of "sleep"; it is the element of the dream that betokens the fulfilment of the cardinal wish to sleep, which Freud considered responsible for all dreaming. Also it represents the maternal breast, usually flattened out, as the infant might perceive it while falling asleep. It appears to be the equivalent or the continuation in sleep, of the breast hallucinated in certain predormescent states, occasionally observed in adults (Isakower, 1938).' Dreams occur which have as their visual element the dream screen alone, without any superimposed dream picture. Such dreams represent 'complete fulfilments of the wish to sleep at the maternal breast after nursing'.

Lewin's papers are primarily concerned with demonstrating the existence of the dream screen, and with discussing its theoretical significance in relation to the general theory of dreams and the psychology of sleep. I intend in this paper to approach the subject from a rather different angle, by giving a fuller analysis of an individual dream of this kind than has been attempted by Lewin. I intend, also, to suggest possible answers to two closely connected clinical questions which arise from the recognition of such dreams. First, at what stage in an analysis are dreams in which the dream screen is visible likely to occur? Secondly, what dynamic process in the patient does their occurrence represent? The answer to the more general question as to the type of patient in which these dreams are likely to be observed is explicit in Lewin's formulation. It is in those with deep oral fixations, whose paramount wish is for union with the breast.

II. Clinical Material

My patient's dream was as follows: 'It felt as though you [the analyst] had taken me under your wing. There was nothing to see in the dream at all. It was like a white sheet.' After telling me the dream he pointed out explicitly that the feeling he had had that I was taking him under my wing was a metaphorical description of the affect colouring the dream and not part of its visual content. He also remarked that he was not happy in describing the dream as a white sheet, but that it was the best he could do to convey the peculiar impression that the dream had made. He gave three immediate associations. First, he had had the same experience, including the awareness of a white sheet of light, during the previous analytical session, but had thought it too silly to mention. Secondly, the night of the dream had been the best night's sleep he could ever remember having had. Thirdly, the dream had recurred three or four times during the night.

In order to understand this dream it is necessary to know something of, first, the patient's history and symptoms, and, secondly, the analytical work preceding and following the dream.

The patient was a married man of forty-five. He was several years younger than any of his brothers and sisters, two of whom committed suicide following depressive illnesses. His

mother was a dominating character, whom he alternatively feared and idealized. I have the impression that she was a woman who resented her children growing up and who could love them only so long as they were totally dependent on her. There is no direct evidence about breast-feeding and weaning, though I am inclined to believe that my patient was correct in his belief that he was weaned rather late. His father was a kindly, meek, unassuming man, who was often away from home.

He had, when he came to analysis, next to no belief in his own masculinity. He was virtually impotent, had a deep sense of guilt about masturbation, suffered from headaches, attacks of giddiness with vomiting closely resembling Menière's Disease, psychogenic deafness and short sight, and complained of feelings of unreality in his arms and legs, which on occasion felt as though they had swollen to two or three times their real size. From early on in the analysis it was clear that his sense of guilt centred round his unconscious hostility to his mother. His masturbation, which was without conscious phantasy, represented an attack on her, both in terms of defiance of her prohibitions and of urinary attack. (As a child he had been enuretic.) It also represented a rejection of her and of women in general. His visual and auditory symptoms constituted defences against scopophilic and listening interests, which had the unconscious significance of oral-sadistic incorporation. The feelings of unreality in his limbs represented defences against wishes to hit and kick.

His giddiness differed from his other symptoms in the fact that the sadism was uppermost, whereas in his other symptoms the defence against sadism was most apparent. Fundamentally it represented the wish that his internalized mother should disintegrate. He once said jokingly: 'Everything was going round so fast that I wonder the house didn't fall down.' The previous night he had dreamt that an engineer had told him that almost the whole house would have to be pulled down before electricity could be installed. Here the house clearly symbolized not only his ego, which he felt to be in need of almost complete reconstruction before he could achieve potency, but also, or, rather, more specifically, that part of his ego which had been formed by introjection of his mother (Schilder, 1930).

In addition to their oral-sadistic significance these symptoms had also a genital, sexual meaning. For instance, the swelling of his limbs symbolized erection and was related to a feeling that his penis was abnormally small. The giddiness represented orgasm as well as a wish to destroy his introjected mother. The worst attack he ever had, with frequent vomiting during the analytical hour, was precipitated by the expectation of an outstanding professional success. The symptom began after he had achieved promotion out of an occupation which his father had practised for many years without any advancement. However, during the part of the analysis with which we are concerned here, the important, dynamic interpretations were undoubtedly those given at the oral level.

His relation to his wife was profoundly disturbed by projection of the maternal imago on to her. Consciously he idealized her and thought her perfect, but he suffered from compulsive wishes to be catty and sarcastic to her, while his symptoms served the purpose of preventing her enjoying herself and compelling her to look after him. Attempts at sexual intercourse were disturbed by visual images of his mother intruding themselves on his image of his wife.

In general, the analysis of his symptoms led to three conclusions. First, the symptoms were a defence against guilt and depression about his hostility to his mother. Secondly, he was orally dependent on her. In this connexion it is significant that he had sucked his thumb all his life. This dependence expressed itself during the analysis as a dependence on his wife and on me. Thirdly, he had attempted to resolve his difficulties with his mother by identification with her. His relationships both with his wife and with me were based on a narcissistic identification. His attitude to me was that he defended himself against having any feelings about me. He took my interpretations and worked on them himself, without allowing them to become part of an object-relationship existing between us. In other words, he tried to be his own analyst.

As regards the relation of his symptoms to depression, it was very striking how circumstances, which prior to the analysis would have made him deaf or giddy, came later to make him depressed. He once made the interesting comment that depression with insight into its causes is more tolerable than symptoms. The operative phrase there was, I think, 'with insight'.

As a result of the identification with his mother passive homosexual feelings were important. Yearnings for the breast and mother were

displaced on to the penis and father-figures. Wishes to look at the male genital were particularly strong, and he could remember thinking as a child that his father's penis was a sort of breast. His dominant infantile theory of sexual intercourse was undoubtedly fellatio. This displacement from breast to penis is important in the material leading up to the dream screen dream.

By a fortnight before the dream, which occurred in the tenth month of analysis, he had acquired a large measure of genuine insight into his problems and was clearly conscious of the mixture of hostility, dependence and identification that characterized his relationship with his wife. In relation to me, however, he had no conscious feelings and was clearly defending himself against the possibility of feeling dependent on me. The relatively superficial reasons for this were, first, that he feared my impending holidays, and, secondly, the homosexual implications of being dependent on a male analyst. From a deeper point of view it was due to a fear of hostility, both his own and mine. It so happened that at this time he had to go out of London for two days in the middle of the week, and, for the first time since the beginning of the analysis, he was separated from both his wife and me at the same time. His giddiness and deafness returned while he was away, and on his first night back in London he had the following dream: 'You gave me a bottle of Schnapps. The bottle was of a curious shape and had two different fluids in it. One of them was milk. I was too embarrassed by the gift to thank you.' I interpreted this dream as showing his unconscious oral dependence on me, a dependence he had been denying while he was away. This interpretation was accepted only intellectually, and the analysis turned to the question of why he had been too embarrassed to thank me.

He told me his behaviour in the dream was characteristic of him. He found it difficult to accept gifts, or, indeed, offered pleasures of any kind. This was due not so much to a sense of guilt as to a feeling that acceptance put him in the power of the donor. He was particularly frightened of being tantalized. He had the feeling that if he admitted to wanting anything it would immediately be taken away from him. In other words, he was unable to accept a 'good' external object for fear that it would turn out to be 'bad' and hostile. Experiences of being teased contributed to this fear, but fundamentally it was related to a projection of his own wishes to frustrate, as was shown by the habit, which he had at this time, of tantalizing me by telling me at the beginning of each hour that he had dreamt the previous night but could not remember the dream. In doing this he was using dreams as such to represent breasts and frustrating me in the same way as he felt his mother had frustrated him.

The unconscious oral longings for the analyst as a 'good' external object were also shown by an hallucination which he had at this time. He was in church, and while listening to the lesson he distinctly saw the reader's penis with urine flowing from it. The connexion here between urinary flow and speech—the means by which the analyst gives himself to the patient—left no doubt that this experience represented an attempt at hallucinatory fulfilment of oral longings for the analyst. This interpretation was confirmed by the facility he displayed at this time in seeing resemblances to the penis in various cracks and shadows on the consulting-room wall. This hallucination, as well as others which occurred during the early part of the analysis, should really be described as a pseudo-hallucination, since it was immediately dismissed as absurd, even though it had all the vividness of a true perception.

The dream screen dream occurred at this juncture. In the light of the preceding material its meaning was fairly clear. It represented the successful fulfilment in sleep of the wish for oral union with the analyst, who was taking the rôle of the mother's breast (and the father's penis conceived of as a breast). This oral union was an external object-relationship, and the real importance of the dream was that it marked the shift from a narcissistic attitude of identification with an internal object to one of turning towards an external object, even though the external object still bore the projected imago of the phantasied breast. The analyst was accepted as a helping, protecting figure—'it felt as though you had taken me under your wing'—instead of his being someone who had to be kept at a distance for fear of his turning out to be threatening and dangerous.

Although from this dream we may assume an advance, the underlying phantasy of union with the mother had also an important defensive function. As described later, the establishment of an object-relationship with the analyst necessitated his using various manic mechanisms, which enabled him to deny the existence of

guilt about hostility to his mother. The dream was not simply a wish-fulfilment of his oral longings; it represented in addition a defensive merging of the ego and super-ego, a process which, according to Rado (1928), ' is the faithful intrapsychic repetition of that fusing with the mother that takes place during drinking at her breast '.

The fact that the night of the dream was the best night's sleep he could ever remember having had was the result of the relinquishment of his narcissistic attitude. There was considerable material to show that sleep, of which he had an unusually great need, represented for him a defensive regression to a state of narcissism rather than a normal psycho-physiological satisfaction. He slept more the worse his symptoms were and could, indeed, fall asleep while feeling giddy. He always slept in the intra-uterine posture, and when upset sucked his thumb while falling asleep. One night, when he might well have been disturbed by his wife's restlessness, he dreamt that a cat was purring—a very apt symbol for a state of narcissistic withdrawal. In just the same way as sexual intercourse is more satisfying than masturbation and feeding at the breast is more nourishing than sucking a thumb, so the change from a narcissistic orientation to an object-seeking one led to a change in the quality of his sleep and an increase in the satisfaction he derived from it. [Cf. Stone's (1947) distinction between narcissistic sleep based on ' refusal or inability to nurse at the breast ' and normal sleep resulting from oral gratification.]

The experience of seeing a white sheet identical with the dream screen during the previous analytical session was not especially noted at the time, except as confirmation of the view that the screen in the dream referred to the analyst. Its theoretical significance, to which I shall return later, would seem to lie in the fact that it was a ' blank ' hallucination which occurred after an hallucination with visual content and before a dream without visual content.

The fact that the dream was dreamt three or four times during the night is interesting in view of Lewin's (1948) conclusion that the repetition of dreams may refer to multiple or interrupted feeds. Another determinant was, probably, that the dream occurred on a Sunday night, that is, three nights after his last session with the analyst.

The interpretation of this dream as representing the abandonment of an attitude of narcissistic identification with his mother was confirmed by the further progress of the analysis. In the same hour as he told me the dream he described a change in his feeling towards me, a change which he expressed in terms of ' thinking of you as a human being for the first time '. A week later I took a fortnight's holiday, and on my return he reported that he had felt very well during my absence. This he attributed, quite correctly, to his having been able to admit missing me. He also reported two dreams which he had had during the holiday. The first was that he was his father and yet was himself too. He, or his father, had an erect penis, of which he was frightened. This clearly meant that he was sufficiently free of his maternal identification to wish to take up a masculine position, but that his fear of his mother still made such a position untenable.

In the second dream the dream screen was again visible, though this time visual elements were superimposed upon it. It consisted of ' a canvas, or perhaps a cinema screen, which was somehow also one of the walls of the consulting-room. On it were depicted all the things that I wanted to tell you when you came back from your holidays. But the only detail I can remember clearly was a submarine in dock. The water was running out of the dock and by the end of the dream the submarine was high and dry.' There were several associations. He had in fact visited a submarine a few days before, and, although it was in harbour, had feared that it might submerge while he was in it. As a child he had lived near the sea and a recurrent anxiety of his had been that he might be drowned by a tidal wave coming in from the sea. The fear he had then as a child he recognized as similar to moments of panic he had experienced in adult life when surrounded by a surging crowd. His last and most revealing association was that while attempting sexual intercourse the previous evening he had felt his mother's power over him receding like an ebbing tide. The dream was therefore a pictorial representation of liberation from his internal mother, a liberation which was not entirely welcome, for the phrase ' high and dry ' referred to a feeling which another patient of mine, rather similarly placed, called ' the limbo of being neither male nor female '.

The form of this dream supports Lewin's view that the dream screen represents the breast

during sleep while 'the visual elements . . . represent the psychic elements disturbing the wish for sleep'. The things that he wanted to tell me about were the things that were disturbing him during my absence, and which, if he had had the opportunity of telling to me, would have enabled his relationship to me to be maintained without frustration.

As was to be expected, the establishment of the analyst as a 'good' external object necessitated the use of the mechanism of idealization. The threat of an impending account led him to dream of me as Sir Stafford Cripps. His associations failed to establish any connexion between the Chancellor of the Exchequer and demands for money. They were concerned entirely with his indifference to worldly things and the frugality of his personal life. The analyst had to be above worldly things, like the angel that at some periods of his childhood he had imagined in his mother. Without this idealization he would have had to contend with an analyst as avaricious and demanding as, at other periods, he had felt his mother to be.

The further progress of the analysis had no direct bearing on the problem of the dream screen, though in retrospect it was clear that the period of the screen dream had been a turning point in his development. After the dream several of his symptoms ceased entirely, e.g. his attacks of giddiness and his tendency to hallucination. He lost his capacity for defensive sleep, and there was no recurrence of narcissistic defences against the transference. As foreshadowed in his dream of being his father, the analysis became increasingly concerned with genital problems. It was found that considerable genital development had, in fact, occurred, and that the early part of the analysis had been dealing with a partial regression to the oral level following traumata at the genital.

III. Theoretical Discussion

The material presented in the previous section can be summarized as follows: A visually blank dream of the kind described by Lewin occurred during the analysis of a patient with oral fixations. Its occurrence marked the renunciation of a state of narcissistic identification with his mother and cathexis of the analyst as an external object. This re-orientation involved projection of the internalized mother on to the analyst, who was idealized as a defence against fear of her hostility. The change marked an advance, since it enabled the patient to progress towards genital identification with his father, while the change in the quality of the transference made accessible anxieties associated with his infantile object-relationships. The dream represented the fulfilment in phantasy of oral longings for the analyst, and the establishment of an object-relationship with him.

Any importance these observations may have rests in the possibility that screen dreams typically have a significance of this kind. The clinical data given by Lewin do not lend themselves to any detailed comparison of his example of a pure screen dream and mine. The bare facts of his case do, however, suggest that some similar process was in operation. His patient was a schizophrenic girl. Her illness began with a stupor, and on four separate occasions she had what she called a 'no dream' accompanied by genital orgasm. Each dream followed a satisfying experience consisting of a meal and shopping expedition with a mother-substitute and heralded the onset of a hypomanic phase, during which she had erotically satisfying delusions. Lewin, following Abraham (1924), interprets both the orgasms and the delusions as primarily oral in origin, despite their expression in genital terms. Although orally fixated, my patient was certainly not schizophrenic, and, even if it were possible, any detailed comparison of the two cases would involve a discussion of the diagnostic problems raised by my patient which would go beyond the scope of this paper. Despite this, it is perhaps possible to discern an analogous process occurring in the two cases. My patient's dream marked a change from a neurotic narcissistic state to object-cathexis, while Lewin's patient's dream marked a change from a psychotic narcissistic state to a hypomanic one, in which hallucinated, projected objects were treated as real and satisfying. The difference between the two would seem to lie in the fact that my patient's capacity for discriminating between external reality and phantasy was unimpaired, as a result of which the projection of internal objects led to the development of a positive transference, which could be analysed, whereas in Lewin's case it led to delusion.

The question naturally arises as to whether my patient's condition after the dream was in any way manic. Psychiatrically speaking, this was, so far as I could observe, not the case, and there were no signs of over-activity or elation. For the next few months, however, he expressed

hatred of his mother and had dreams of her dying—in reality, she had died many years previously—without any conscious guilt or remorse, and interpretations of material which suggested the presence of unconscious guilt met with no apparent response. This denial of psychical reality was made possible by the idealized nature of his positive transference, which made anger with the analyst inconceivable, and by the presence of various omnipotent phantasies, which made him feel immune from frustration and attack by his mother. These phantasies reached consciousness in terms of an unrealistically optimistic attitude to money and became accessible through the analysis of fears that a mother-substitute would make excessive financial demands upon him. The analysis of these fears led to conscious feelings of remorse and wishes to make amends for the unhappiness his neurosis had caused his family. He presented, in fact, a picture corresponding closely to that described by Melanie Klein (1935) as characteristic of the ' manic position ' taken up as a defence against guilt and paranoid anxieties. The fact that his behaviour was in no way hypomanic is, like his development of a positive transference, attributable to the integrity of his capacity for reality-testing. The co-existence of omnipotent phantasies and a well-developed sense of reality seems to have been largely responsible for his success as a business man. He was able to take financial risks which most people would have considered unjustified by the circumstances, and then compensated for his rashness by a very realistic handling of the situations into which it had led him.

It is now possible to suggest an answer to the questions posed at the beginning of this paper. Dreams showing the dream screen are likely to occur when patients with narcissistic fixations are attempting to re-establish emotional contact with the external world. This attempt may be successful, as would appear to have been the case with my patient, or unsuccessful, as in Lewin's [Lewin (1949) specifically draws attention to his patient's complete inaccessibility during her hypomanic states.] In either case the mechanism employed is projection or externalization, a mechanism which, as first described by Freud (1911), represents an attempt to re-cathect the external world. The prototype of this process is probably the moment, to which Winnicott (1945) has drawn attention, when the hungry infant projects the hallucinated breast on to the real one. There are three possible outcomes to this superimposition of hallucinated on to real object. First, the real object may be accepted as satisfying, in which case there is a shift of cathexis from the hallucinated object to the real one. In so far as this happens, the cumulative effect of repeated satisfying experiences will be to strengthen the ego's capacity to cathect the external world and lay the foundations for the development of a sense of reality. The tendency to hallucinate the object in periods of frustration will gradually be replaced by the capacity to phantasy about a memory of it. Secondly, the real object may be rejected, in which case the hallucinated object continues to be cathected. This is, one surmises, what happens in the case of those anxious, overexcited infants, who, as described by e.g. Ribble (1943), become stuporous when offered the breast. This is an outcome the repetition of which over any extended period of time is incompatible with life, but, in so far as it occurs, it must militate against the establishment of a firm cathexis of the external world and predispose to states of withdrawal. Thirdly, the real object is partially accepted, so that both the hallucinated and the real object are cathected. In this case a split in the ego takes place, one part continuing to cathect the hallucinated object and remaining fixated on it, the other cathecting the real, external object and capable of further development. Whether or not my patient sucked his thumb while at the breast, like the babies referred to by Winnicott, his ability simultaneously to hallucinate objects and to dismiss them as unreal suggests the presence in his ego of a split of this kind, dating from the period when the sense of reality is being established.

In this connexion the series of events—(*a*) hallucination of a penis, (*b*) hallucination of a white sheet of light during an analytical session, (*c*) screen dream, and (*d*) dream with visual elements superimposed on the screen—becomes significant. It reproduced in the analysis the series—(*a*) hallucination of the breast by the hungry infant, (*b*) superimposition of the hallucinated breast on to the real one, (*c*) cathexis of the breast, and (*d*) the retention in memory of a phantasy of the breast. The cathexis of the analyst as a ' good ' external object made hallucinatory fulfilment of his oral longings unnecessary, and henceforth hallucination was replaced by conscious feelings of

dependence on the analyst. The second screen dream, in which ' all the things I wanted to tell you ' were depicted on the screen, was related to a conscious wish for the analyst's return from holiday and represented the fulfilment in sleep of the phantasy of being reunited with him in the analytical session. Since the capacity to hallucinate was possessed by only part of his ego, the other part being capable of rejecting the hallucinations as unreal, the loss of the capacity to hallucinate marked the reuniting of a split in the ego and the achievement by the whole ego of that stage in development at which hallucination is replaced by phantasy.

My main purpose in this paper has been to make a clinical contribution to the problem of the dream screen by reporting in some detail the psycho-analytical context in which a blank dream occurred. My observations suggest that it may be possible to make two additions to Lewin's interpretation of these dreams as representing ' complete fulfilments of the wish to sleep at the maternal breast after nursing '. First the fantasy of having fulfilled the wish to sleep at the breast represents an attempt to re-establish an object-relationship with the mother, an attempt which may, as in my patient, be successful and lead to an advance in ego-development. Secondly, this phantasy has a defensive function, since it enables anxieties associated with frustration at the breast to be denied.

(Received October 20, 1950.)

REFERENCES

Abraham, Karl (1924). ' A Short Study of the Development of the Libido ', *Selected Papers* (1927).

Fenichel, Otto (1945). *The Psychoanalytic Theory of Neurosis*, Ch. IV. (London: Kegan Paul.)

Freud, S. (1911). ' Psycho-Analytic Notes upon an Autobiographical Account of a Case of Paranoia ', *Collected Papers*, **3.**

Isakower, Otto (1938). ' A Contribution to the Patho-psychology of Phenomena Associated with Falling Asleep ', *Int. J. Psycho-Anal.*, **19,**

Klein, Melanie (1935). ' A Contribution to the Psychogenesis of Manic-Depressive States ', *Contributions to Psycho-Analysis*, 1948.

Lewin, Bertram D. (1946). ' Sleep, the Mouth and the Dream Screen ', *Psychoanal. Quart.*, **15.**

Lewin, Bertram D. (1948). ' Inferences from the Dream Screen ', *Int. J. Psycho-Anal.*, **29.**

—— (1949). ' Mania and Sleep ', *Psychoanal. Quart.*, **18.**

Rado, S. (1928). ' The Problem of Melancholia ', *Int. J. Psycho-Anal.*, **9.**

Ribble, M. A. (1943). *The Rights of Infants.* (New York: Columbia University Press.)

Schilder, P. (1930). ' The Unity of Body, Sadism and Dizziness ', *Psychoanal. Rev.*, **17.**

Stone, Leo (1947). ' Transference Sleep in a Neurosis with Duodenal Ulcer ', *Int. J. Psycho-Anal.*, **28.**

Winnicott, D. W. (1945). ' Primitive Emotional Development ', *ibid.*, **26.**

PATHOLOGICAL GENEROSITY

By HILDE LEWINSKY, MANCHESTER

About thirty-five years ago, Karl Abraham, in his paper on 'Spending Money in a State of Anxiety' (1), drew attention to the fact that the young science of psycho-analysis was more interested in understanding meanness than in its apparent opposite. Three years before Abraham's paper, however, Ernest Jones, in his article 'The God Complex' (7), had already described a syndrome in which spending, giving and generosity played some part. In this paper, the desire for omnipotence, including omniscience, took the central position, and generosity, in connexion with the God Complex, was explained as being due to the relative unimportance of the gifts in comparison to the phantasied possessions.

Furthermore, such apparent virtues would not be in the foreground of practical analytical work. The patients approved of them. Later, character analysis, trying to deal with new groups of patients, directed its searchlight on the so-called virtues as well. But even so, generosity did not arouse as much interest as, e.g. overcleanliness.

Wherever generosity was mentioned, it was described as a reaction formation against greed, following Freud in his description in the *Three Essays* (5).

Anna Freud, dealing with *The Ego and the Mechanisms of Defence* (4), put greater stress on this trait. She clearly showed that the simple explanation of reaction formation did not fully cover the syndrome.

From another angle, the problem of 'giving' found an important place in the description of the mental make-up of the individual.

In all her writings since 1927, Melanie Klein stresses the aspect of reparation based on depressive and persecutory anxiety. Naturally giving plays a great rôle in reparation. An attempt at omnipotent reparation by special generosity is then due to the feeling of overgreat destructiveness, which can be repaired only by overmuch giving (10). Throughout Melanie Klein's writings there are numerous examples of the symbolic values of the gifts, representing the children robbed from the mother, the father's penis, etc.

The two patients from whose analysis I propose to give you some extracts were in treatment with me during the war. During that time the economic aspects of life were much in the foreground. Individuals who in ordinary circumstances might be considered mean, would probably excel in their savings groups. My two patients, confronted with this altered reality, found themselves obliged to acknowledge their symptoms.

Both women had in common:

(1) father fixation;
(2) penis envy;
(3) they suffered from a reduction of orgastic potency and occasional incapacity to reach a climax (15).

The penis envy had in both cases been strongly supported by the parents, who were very much disappointed about the sex of the children. One patient, A, was an only child and the parents had wanted a boy. A's parents, living in South Africa, sent A to England at the age of two years, to be brought up by a maternal aunt. The other patient, B, was conceived shortly after the death of a son of eight years, who had been the second child of her parents, the first being a daughter. B's parents had fervently hoped to replace their son.

In the object relations of both women, giving played an immense part. This giving was not necessarily only of a clearly material character, but extended to thoughts, interests, care, etc. Both managed to get themselves repeatedly into relationships where their giving was so profuse that the recipients, even if they wished to reply, felt too overpowered to do so.

The analysis of the situations in which generosity occurred provided four main types of giving, which I call:

(1) Propitiatory.
(2) Assertive.
(3) Fetishistic.
(4) Deceptive.

(1) The first type—propitiatory giving—is self-explanatory. For instance, A would never visit any of her friends without taking them some present; she felt that she would not otherwise be welcome, just as she herself had not been welcome to her parents.

(2) Assertive giving: Anna Freud in *The Ego and the Mechanisms of Defence* describes the case of a girl who in a phase of exhibitionistic desire and penis envy would constantly make empty promises, thus disappointing the other siblings. Clearly, this form of boasting led to unpopularity and could therefore not be used by my patients, whose original aim was to be loved. As neither of them could boast of the cherished possession of a penis or of the father as a lover, they tried to reassure themselves on the anal level of possessions and by urethral ambitious endeavours. But as they wanted to be loved, not to be envied, their constant boast 'I have' or 'I can' had to become 'I have something for you' and 'I can do so-and-so for you', and the assertions had to be proved by generous actions. With both patients the underlying idea was that they—the children—were as good as boys and should therefore be loved accordingly. At the same time, they tried to prove their goodness to themselves. I think it is interesting in this connexion that the word 'generous' means 'of noble birth'.

The need to substantiate the assertions in 'kind' was supported by their own inability to bear frustration without neurotic reaction; their despair and hate about any 'No' led to a fear of refusing others. In adolescence, forms of behaviour developed which appeared nymphomanic, 'the girl who could not say no'. In reality, the desire for flirtation with its possibilities of narcissistic gain was much greater than the desire for intercourse. Only in analysis, as a woman of thirty-six, could A deal with her horror of being considered a flirt. She sharply criticized any woman who used the desires she aroused for her own advantage; she railed about the unfairness of such behaviour. Clearly the unfairness consisted mainly in others doing what she did not dare to do herself.

Naturally there were strong narcissistic gratifications in my patients' generous giving. One rather more obscure narcissistic source was built on the following early experience. The little girl B was on holiday; she wanted to join in the play of other—older—children. They played shop. She produced a box of chocolate cigars and naturally had a very quick turnover; her 'shop' was beleaguered and she soon 'sold' the lot. She delighted in the game and her popularity. After a very short time she found herself without chocolate cigars, without further customers and with a great heap of money in the form of pebbles. She was heartbroken. Naturally the whole situation was possible only on a neurotic basis, as the child was above the average in intelligence. The oral, anal and phallic significance is clear. The experience worked as a trauma. The narcissistic wound to her own 'simple-mindedness' for having believed herself popular and liked had to be dealt with. It could not be made good by a new box of chocolate cigars from the parents.

According to Freud's description in *Instincts and their Vicissitudes* (6), there are two ways of turning an instinct into its opposite:

(1) by change from active to passive or *vice versa*, and
(2) by change of context.

The described situation could be dealt with:

(1) by not wanting to play at all;
(2) by either wanting something for nothing or giving up the expectation to get anything in return.

The first way, not wanting to play, is alien to the child. The second, wanting something for nothing, would not heal the narcissistic wound. However, she retained a great hankering after this form of reaction, which later showed itself in a desire for gambling. Giving something for nothing seemed the only way in which she might forget her 'stupidity'. This experience, added to the awareness that she, as a girl, was a disappointment to her parents, has fixed it in B's mind that she could not possibly be loved for herself, but only for what she could give. Joan Rivière in *Hate, Greed and Aggression* (11), pointed out that 'to have friends and to be liked proves to people that they themselves are good, i.e. that the dangerousness in them is non-existent or safely disposed of. Thus by collecting goodness all round them . . . , they recreate for themselves a kind of substitute mother's breast which . . . is naturally the defence *par excellence* against the possibility either of destitution or destructiveness arising in oneself."

In B's case, she could not collect friends without giving, so that these friends could not be a substitute for the 'ever-bountiful' mother-breast. On the contrary, in the vicious circle of her neurotic responses, B felt in constant need to be such a substitute to others.

A's and B's generosity appeared to contain all the elements of the manic position as described by Melanie Klein in *Mourning and its Relation to Manic-Depressive States* (9). There certainly was a desire for ' triumph closely bound up with contempt and omnipotence ', and further ' the desire to control the object '. The sadistic gratification of ' overcoming and humiliating the object ' was, however, repressed. Thus, the ' benign circle started by the act ' did not appear to be broken, and the patients were glad to be in a position in which they turned the tables and showed up the cupidity and greed of others.

The third type of giving, which I called, for want of a better word, ' fetishistic ', took place on various occasions when one would have expected the patients to feel hate and envy.

Following the pattern of the Œdipus situation, both women repeatedly had love-relationships in which the man, though continuing his affair with them, had another woman whom he preferred. Instead of hate and unfriendliness against the rival, they felt and showed a form of feverish love and behaved in a generous and helpful manner, e.g. by preparing a meal for the other woman's arrival, putting out flowers, etc. The identification with the man played a part in this behaviour, but a more important component was their erroneous conception of reality, their belief in ultimate success. Their behaviour calls to mind the description of Reich in *The Function of Orgasm* (15), where he describes a boy's attempt at conquering his mother. ' This boy had not taken up the fight with his rival (his elder brother) but shortly before puberty he *decided* to conquer the love of his mother, who idolised her eldest son, by agreeing with this idolization. He had made the experience quite often that this mother loved those people who praised her eldest son and hated those who were against him.' The generosity shown in such situations could also be explained as an attempt at reparation for the damage done to the parents. But both women emphasized that there was no other chance to keep even the little they had. Their choice was not between All and Nothing, but between ' Precious Little ' and Nothing. Following this trend of thought, A said: ' I want all but can't have it; I can't bear to have nothing; I must try to keep the little I have got. I want to keep this small space in his life.'

' What comes into your mind about it? '

' A cot in my parents' bedroom.'

This association led to the working through of her desire to watch the parental intercourse. The main determinant for the presents given in this triangular situation became clear: the patient identified herself not with the presentee *but with the present*, trying to be present through her gift. The idea is closely connected—though it works in the opposite direction—with that degree of fetishism described by Freud in the *Three Essays* (5). Freud quotes there from Goethe's *Faust*: ' Give me a kerchief from her breast, A garter that her knee has pressed.'

The desire to be the child with the parents appears at first to correspond to the wish to be the good child as Melanie Klein described it in *Love, Hate and Reparation* (11). ' Ultimately in making sacrifices . . . we play the part of a good parent, . . . we also play the part of the good child towards his parents, which we wished to do in the past and are now acting out in the present.' But the power of this desire does not originate in any intention to be a ' good child ' as the parents understand this expression, but —on the contrary—to see what the child was forbidden to see. Infantile curiosity was the powerful motive in the generosity shown in these triangular situations, e.g. in giving an entirely uncalled-for present of food and wine to such a couple, A felt able in a vague way to know what this man and this woman would do when when they were together. She realized this later when she found out that the people had not used her gift. Her curiosity was very strong. To be ' in the know ' made her feel less insignificant and allowed her to pretend to benevolent omniscience: whatever went on happened with her knowledge, equivalent to ' her permission '; thus she denied that she had no power to alter it.

When working through this material, A laughingly connected another of her generous gestures with the same forbidden wish: often, on holidays, she had offered to take snapshots of couples or of groups, in order to allow the would-be photographer to join in the group picture. Here she certainly played the good child who helped the parents to be together and who had the gratification of seeing them together through her grace. The desire to be in the picture herself in place of the mother remained frustrated.

The fourth type of generosity I called deceptive. It was the only form of faintly anonymous giving which occurred in these patients. The deception—in contrast to that of the impostor—

was not to the disadvantage of the deceived. One example: B, who works in an office, is sent by her superior, for whom she has a ' passion ', to buy an inexpensive fountain pen. B buys a first-class pen, and asks the shop-assistant to give her a bill for sixpence less than the price her superior had allowed her to spend; she pays the rest herself. The narcissistic gain is great, she is pronounced a ' wizard ', and, although she herself knows that she cannot really produce these magic results, she can prove to herself that cupidity paralyses the judgment of reality in others.

As the need for giving was extraordinarily strong, I was not astonished to hear from A that she had frequently stolen in order to be able to give. We meet this combination relatively often in Child Guidance Clinic work, where the history starts with stealing and giving the stolen goods to other children. In such giving away of stolen goods, the attempt to sidetrack guilt is clearly important. The overrating of material possessions is also clear. But the desire to be thought of as powerful played the main part, at least in the case of A. A later managed to become a valuable officer in the Control Commission in Germany, where the giving out of material comforts and forceful ' scrounging ' for her protégées was a permitted and important feature of her work.

In ' Manifestations of the Female Castration Complex ' (2), Karl Abraham has described the character and behaviour of frigid women with strong penis envy. He says that they tried to get the present of the penis by violence. Their vengeful attitude finds an expression *par excellence* in frigidity: to disappoint the man, to raise false hopes. The reason why A and B dealt in a different way with the same desires lay in their still existing hope. I was able to show them the pathology of their giving through their attitude to lending. Here their attitude was the opposite of the proverb ' Better give a shilling than lend a half-crown and lose it.' They much preferred giving a half-crown to lending and losing a shilling. By giving something they would get a reward either in their own minds or actually in the acknowledgement of the recipient; in lending and losing they felt cheated out of any recognition, out of any thanks. Their bitterness gave the clue to their still existing hope. Hours were filled with their reproaches and complaints that other people were not generous or had let them down; in short, that they had not been repaid. Their firm belief in an ultimate reciprocity came to the surface. This belief was so elemental that I thought it worth while to enquire into the aspect of generosity as seen in primitive peoples.

Money-Kyrle in *Superstition and Society* (14), describing the Normanby Islanders, says ' They like to appear generous, for generosity is part of their group ideal, but they are really very greedy.' Malinowski in *Crime and Custom in Savage Society* (12) describes generosity as an essential part of the social system of the Trobriand Islanders: ' Generosity is the highest virtue to them.' Generosity is not however a one-sided affair in their social system, ' but in this and in all the manifold activities of economic order, the social behaviour of the natives is based on a well-assessed give-and-take, always mentally ticked off and in the long run balanced'. Malinowski also quotes Professor Thurnwald (1921, *Die Gemeinde der Banaro*), who says: ' We call the symmetry of actions the principle of reciprocity. This is deeply embedded in human feeling and has always had the greatest importance in social life.'

Margaret Mead, in *Male and Female* (13), describes three types of maternal behaviour towards the child: symmetrical, complementary and reciprocal. Of the latter, built on the emphasis on elimination, she writes that in reciprocal phrasings of relationship, love, trust, tears, may become commodities just as much as physical objects, but the interchange of the physical objects remains the prototype.

The belief in reciprocity is an integral part of homœopathic or imitative magic. Marie Bonaparte, in *La Pensée magique chez le primitif* (3), describes magic as ' a purposeful technique, a medium for the government of the forces of the world, of people, of ghosts '. This description links up with that of the manic position as quoted from Melanie Klein. In speaking of a technique, Marie Bonaparte follows Reinach, who called magic the strategy of animism, and Hubert and Mauss, who spoke of the technique of animism.

At the other end of civilization we find traces of the reciprocal attitude in all social manners. All ethics, and especially Christian ethics, stress the expectation that generosity will be generously repaid. Melanie Klein, in ' Criminal Tendencies in Normal Children ' (8) emphasizes that ' In the Unconscious the Biblical precept " an eye for an eye " is at work.' This precept—though here meant in a retaliatory

fashion—is an equivalent to 'Do unto others as you want to be done to.' That Christian ethics, for instance, would lend themselves to be used as the means of a technique was illustrated by another patient of mine. Having heard the maxim of the Sermon on the Mount that 'the last will be first', he always used to work his way to the end of any queue.

In the case of Altruism described by Anna Freud (4), the old desires of the patient had not been repressed, but were projected. In both my patients the mechanism of projection dealt only with the principal question: that everyone would like to be loved, to be spoiled, to be looked after. In the particular instances of giving, A and B were on the whole thoughtful of the loved person's wants. But even so, they were sure that they could never bring themselves to give what was really expected of them. This feeling was not entirely due to having disappointed their parents by being girls. In her analysis B found out the early prototype for her depressing conviction. As a child she had clamoured for her mother's presence, wanting to play with her, to have her near, and had told the mother that she wanted her so badly because she loved her. The mother had answered: 'If you love me, you be a good girl and leave me alone.' B managed in her adolescence to get the same reply from a teacher, whom she pursued in a 'crush': 'If you really love me, prove it by leaving me alone.'

It is understandable that both A and B, hysterics on an anal basis, found this concept of love beyond their strength. Their thoughtfulness in giving was a compromise. In contrast to Anna Freud's case, my patients did not feel forbidden to get anything for themselves. But what they wanted could only be given by someone else and, in order to be really satisfactory, should be given without their asking for it.

B, explaining her difficulties in asking for something from others, exclaimed in tears: 'What is the good of telling someone "Please kiss me spontaneously".' What they hoped to induce by their pathetic and pathological generosity was to turn the clock back: either to be made male and thus be welcome to the parents; or to be assured and convinced of their welcome as female.

Summary: Giving as concerned in Pathological Generosity has its roots in oral and anal fixations. It is due to an acknowledgement that the direct satisfaction of the greed for love, for a penis, etc., cannot be attained through the sadistic approach. Owing to an incapacity of facing the hopelessness of the desires, the illusion of ultimate reciprocity is introduced. The patients used generosity unconsciously as a technique comparable to homœopathic magic. There were indications that they attempted satisfaction of infantile curiosity by identification with their present.

(Received October 4, 1950.)

BIBLIOGRAPHY

(1) Abraham, Karl (1917). 'The Spending of Money in Anxiety States', *Selected Papers.* (London: Hogarth Press, 1942.)

(2) —— (1920). 'Manifestations of the Female Castration Complex', *ibid.*

(3) Bonaparte, Marie (1935). *La pensée magique chez le primitif.*

(4) Freud, Anna (1936). *The Ego and the Mechanisms of Defence.* (London: Hogarth Press, 1937.)

(5) Freud, Sigmund (1905). *Three Essays on the Theory of Sexuality.* Authorized translation by James Strachey. (London: Imago Publishing Co., 1949.)

(6) —— (1915). 'Instincts and their Vicissitudes', *Collected Papers,* **4.**

(7) Jones, Ernest (1913). 'The God Complex', *Essays in Applied Psycho-Analysis.* (London: Hogarth Press, 1923.)

(8) Klein, Melanie (1927). 'Criminal Tendencies in Normal Children', *Contributions to Psycho-Analysis 1921–1945.* (London: Hogarth Press, 1948.)

(9) —— (1940). 'Mourning and its Relation to Manic-Depressive States', *ibid.*

(10) —— (1945). 'The Œdipus Complex in the Light of Early Anxieties', *ibid.*

(11) —— and Riviere, Joan (1937). *Love, Hate and Reparation.* (London: Hogarth Press.)

(12) Malinowski (1940). *Crime and Custom in Savage Society.*

(13) Mead, Margaret (1950). *Male and Female.*

(14) Money-Kyrle, Roger (1939). *Superstition and Society.* (London: Hogarth Press.)

(15) Reich, Wilhelm (1927). *Die Funktion des Orgasmus.*

RUMPELSTILZKIN IN THE ANALYTICAL SITUATION [1]

By JULIUS L. ROWLEY, London

A single woman of twenty-two, whom for the purposes of this paper I propose to call Emily Standish, suddenly became frightened at a dance and had to rush out of the ballroom. In the succeeding few days, she remained tense and apprehensive, but gradually settled down to a state of undue self-consciousness and a feeling of discomfort when with people, whether men or women, but more especially women. She had been at a university, taken a degree, and had some knowledge of psychology. She considered the question of consulting a psychiatrist, but it was not until eighteen months later that she actually did so, and even then she came to it in a very roundabout way. The consultation led to her starting analysis, which she began at twenty-four, i.e. two years after the more acute symptoms had first occurred. A diagnosis of anxiety hysteria was made, and there were no indications later to alter this. At the first analytic session she stated spontaneously that she knew that in analysis one had to say whatever came into one's mind, and in the following two or three sessions the view was repeatedly expressed that she couldn't see how she would ever be able actually to do this.

She was the eldest of three daughters. Of her early life, the main incidents to which I wish to refer here were her being apparently conceived out of wedlock, and her belief that it was on account of her conception that her parents married. From three to five she had many memories of being forcibly given enemata by her mother for obstinate constipation. Of her present life, it was revealed that sexual intercourse of a sort had been experienced, in which she had some kind of orgasm from very slight stimulation of the pubic region by her partner's hand. When he came to enter her, her pleasure was already completed. Rarely and only with difficulty did she permit penetration. Often he masturbated between her legs or in front of her.

In the first few months of analysis her fairly severe inhibitions, already glimpsed at her first interviews, became more and more blatant. A pattern of behaviour could be very clearly seen, especially in her relationship to men, first to stimulate or excite them usually in a hidden way, but once they had been roused, to frustrate them.

In about the tenth month of analysis the patient began one session by saying that she had had a horrible dream the previous night, which she could not possibly tell the analyst. She intimated quite clearly, however, that it was of a sexual nature, and that the analyst was closely concerned in it. The excitement and frustration pattern was again clearly in evidence. This was interpreted, and other aspects of her inability to tell the dream were worked through in the next four months. These included her attempts to make the analyst into an ideal magical figure, who magically knew the dream and thus relieved her from having to give it up herself—there being a clear link with her early relationship to her mother over the problem of the enemata. Also worked through was her defiant attempt to keep control by rendering the analyst powerless, impotent and castrated—linked with the frustrating side of her pattern.

Progress was maintained, and towards the end of this phase the approaching summer break became a factor. The patient viewed this in two ways: first in the consciously expressed wish to get rid of the dream for the summer, but also in the hope that if she could tell it a day or two before the break, she would be able after the longish interval to avoid working through the dream. In actual fact, only two or three days before the holiday she gave an account of the dream. In it the analyst had come to her bed. He had been able to assure her that insertion of his penis would not be painful, and thereupon intercourse had taken place.

There were many indications that even now

[1] Paper read at the meeting of the British Psycho-Analytical Society on January 17, 1951.

all the details of the dream, as consciously known to her, had not been revealed, and her anxieties about giving up everything were interpreted. Nothing much more was possible. After the holiday, as had before seemed likely, the patient was able to maintain her avoidance of working with what she had revealed, despite the analyst's attempts to make the analytic atmosphere one in which she could do so. In the sixteenth month of analysis, that is, just over a month after the summer break, the patient at one session spoke of having spent the week-end with two of her friends, a man and his wife. It had been quite a complex situation, and the incidents referred to concerning it were obviously richly expressive of the patient's conflicts. The patient freely admitted having love feelings towards the married man—feelings which were even jocularly referred to and accepted by the wife. There had been some coldness between the man and his wife, so that instead of the patient sleeping on her own, as on previous occasions, she and the wife had slept this time in single beds in the married couple's room, while the husband had slept in another room by himself. The patient and the wife had awakened early in the morning and talked for a long time about the husband and his difficulties. Occasionally before this the patient had similarly brought specially rich material to the analysis, but it had been learned that this very richness was to be regarded with great suspicion, as it tended to contain so many possible themes that it was often almost impossible, on account of complicated avoidance mechanisms on the patient's part, to assess which aspects were most important to work with. Indeed it had become a recognized practice in such situations not to be too specific in early interpretations, and a technique had often been adopted of merely recalling to the patient that she had been speaking in analogy of the situation between herself and the analyst. Of course, this too had at such times often been interpreted. The incidents described were felt by the analyst to be of a similar type, so he adopted his usual technique. But this time there was one special difference. The patient had mentioned that her friend's name was Emily Stannard (the similarity in the real names was even closer). At a certain stage, then, when the patient had elaborated to quite a degree on the situation of the week-end, and reference was being made to the use her friend Emily Stannard had been making of her husband—called John—the analyst decided to speak, and said to the patient 'Perhaps Emily Standish is similarly using the situation here.' This led to further work of a routine nature, but is mentioned mainly because of its importance in a respect that became clear only later. It was the first time the analyst had spoken of the patient by her full name, including her first name, and it occurred on this occasion because of the close similarity between the names of the patient and her friend.

Three sessions later the patient revealed that she had again had a horrible dream which she could not possibly tell the analyst. She quickly showed, as with the previous dream, that something of an intimate sexual nature had occurred in it. The work in connexion with the first dream was now run through, but this time at a much quickened tempo. Everything was much more intense than before, so that, this time within a few days, a position almost of impasse was reached, and the patient stated emphatically that she just could not see how she would ever be able to tell the dream. It really did seem a stalemate. In going over, in his own mind, material which might be relevant, the analyst had a hunch that the incident of her friend using her husband was especially important, and, as an opportunity to refer to it soon arose, he did so. The patient responded by saying it was odd that this had happened, as it was linked with the dream. A little later she stated that she knew it had been done to help her, but she still could not take advantage of it. This was then worked through, and the patient's persistent belief that the analyst was a magician who would magically see to all her demands, no matter what she did, became clearer. She was then shown that the rate of further progress lay in her own hands; analysis was not magic.

The patient began the following session by speaking of her changed attitude to her chief at work that morning; of how co-operative she had been. A little later she spoke of an important change that had occurred in her following on some small remark of the analyst four sessions previously. She could not possibly tell what the remark was. She went on to give many circumstantial details of the change that had occurred in her as a result of the remark, and even spoke of dreams in connexion with the change. Moreover, unusually for her, she quickly and spontaneously worked with these dreams, although, as was to be expected from her undue willingness to do this, no further

clue to the remark appeared. Towards the end of the session, she returned to her complete inability to tell the remark. Now at this point the patient had thrice at least indicated her conscious wish to be more co-operative in the analytic situation. It was felt fairly definitely, feebly no doubt but yet somewhat constructively, that she was trying her utmost to give some clue to help the analytic work continue. It might have been valuable only to interpret this, but in fact, in this rather charged situation, previous material entered the analyst's mind. This was that, a little while before telling it then, she had had intercourse with her friend, and despite the fact that he had used a sheath as a contraceptive, she had remained fearful until two menstrual periods had passed that she might be pregnant. She had added that if she had really been pregnant, she would never have revealed this to her friend. The situation of the moment seemed comparable. Some small thing said had affected her and wrought important changes in her, but it was impossible for her to speak of it. It was as though symbolically there had been intercourse, that she had been impregnated with a small thing, a spermatozoon, and was unable to reveal the change in her, her pregnancy. To the analyst also, of course, the possibility of the patient's secret standing symbolically for a pregnancy had always been present. Most of this was put to the patient, who was astounded. 'But that is astonishing', she said, 'that is the dream; now, of course, I may as well tell it.' And she did so. In the dream the analyst had had intercourse with her, and everything seemed satisfactory until she realized he was not wearing a contraceptive sheath. She was unable to do anything about this, and her horror kept mounting until she awoke in great fear.

The patient began the next session with terrific gusto, and inundated the analyst with a rapid flow of words. It was obviously an evacuation, a getting rid of tension, but after a bit came a pause, and it was possible to show her again—it had occurred frequently before—that by such an outpouring she avoided dealing completely with any one item. This led fairly directly to her not having yet revealed the so-called small remark. She responded that this was no longer difficult to tell. Even so, however, she could not tell it directly. She began by saying it had occurred in the period when she had been talking of the week-end with her married friends, and, as she now put it, the analyst had referred to her using him. This had disturbed her, as it had made her have to consider that the analyst might think she had feelings for him similar to those she had for John—Emily Stannard's husband. Then, she added—and now she could be fairly direct—the real point was in connexion with her name. The analyst had called her by her full name, using both Christian name and surname. This had struck her forcibly and surprised her.

And so, at last, the analyst could realize that this was the key to the work described. Her being named must have affected her deeply, and many of the conflicts of the recent sessions must have centred round it. It must also, of course, be borne in mind that the patient herself had played a major rôle in being thus named, in that she had spoken to the analyst of a friend whose name was so similar to her own.

At this stage in the work the analyst became aware of a specially interesting feature. The work as described had been carried through in quite a stimulating and exciting atmosphere. The work in connexion with constructing the dream had been especially demanding on the analyst, so that when his work had some obvious effect, he had quite a feeling of accomplishment. In the succeeding session as described, a not dissimilar feeling again occurred, yet somehow this time—when, in fact, a more important stage of the analytic work had obviously been reached—there was a feeling of anticlimax rather than of climax. In considering it, the analyst could then appreciate to the full the patient's pattern of behaviour—that she had indeed been attempting to stimulate him, only to disappoint him later; no climax, as such, having been permitted by the patient to occur. Further, when later it became a matter of putting down in words descriptively what had happened, this inability to make the story an exciting one rising to a full climax became even more striking.

Indeed, despite all attempts to charge the story, even with the addition of minor allowable literary licence, to do so has not seemed possible, and I cannot but feel that there is now in the reader a sense of anticlimax. But this, of course, represents the patient, so that perhaps such a faithful portrayal of the work as has been attempted conveys most clearly in the end the patient's conflicts and her method of dealing with them. In this way, it becomes possible to be aware most clearly of her behaviour, not only in general terms of stimulation and then

of frustration, but even more specifically in symbolic precocious orgasm in the analytic situation itself. There can be little doubt that being named by the analyst aroused intense excitement in her, yet before this could be revealed, the conflict had to be waged mainly at a displaced point, a dream, whose disclosure, although exciting at the time, was later realized to be a pseudo-climax, a precocious relief of tension, so that by the time the real climax should have been reached, tension and excitement had been largely dissipated.

I now wish to discuss the significance and importance a person's name may have for him. That one's name is important, and that there must be a close bond between one's name and the concept of one's person or rather one's ego, is almost certain. Louisa Duss [2] discusses this in a paper on ' The Psychological Function of the Proper Name in the Reconstruction of the Personality of a Schizophrenic '. She raises the question of some patients displacing on to their name a projection of their ego, which she calls an auto-projection of the person into the name. She further asks whether the genesis of the ego is not naturally associated at a given time with a magical conception of the name.

Frazer in *The Golden Bough* discusses at length ' The Taboo of Personal Names ', including the idea of some primitive tribes that to know a person's name may give one power over him—the name again being an extension of the self or ego.

Literature, religious works and folklore are full of references to the significance of the name. An interesting modern example is Oscar Wilde's comedy *The Importance of Being Earnest*, where an abandoned child is given a name only to discover later that his idea that he is a bastard is unfounded, and that the name he had been given was in fact his real name.

What can we deduce in the patient described, concerning the significance to her of being named? Following on it, she certainly changed to quite a degree and made considerable progress, so that there can be little doubt that it had some real effect upon her. It is interesting first to follow what happened directly after her revelation that it was her name that had been the ' small remark ' that had affected her. Although she had stated that being named had made her consider that the analyst might think she had warm feelings towards him, she in fact concentrated mainly on the point that he had spoken it unaffectedly, calmly and straightforwardly, and that therefore she was not disturbing him. Again, although this could mean that she had felt she might have been either exciting or damaging him, it was the damaging aspect that she took up. In this way it became possible in the analytic work to resolve some of her inhibiting anxieties on account of wishes to damage the analyst. With this, it was no longer necessary for her to keep the analyst at a distance, idealized, desexualized, i.e. castrated, in order to preserve him. She could be really aggressive instead of, as previously, dumbly defiant. Only then could the problems connected with the underlying love wishes come to the surface, and the beginning of an attempt to deal with the anxieties connected with such wishes be possible. Moreover, it was not possible for the patient to work through the content of the dreams and some of the rest of the material described. As she said of it herself, it was all too clear, too horrible and impossible to be talked about at that time. It is not, therefore, possible as yet to be sure what particular meaning all the work described had for the patient, although it is obvious that once the content is examined, it is possible to construct many of her conflicts, especially when we link it with her certainty that she was conceived out of wedlock. To begin with, it is clearly suggestive of mother-identification problems on account of the features concerning unchastity, and fantasies of being impregnated with bastard babies. However, with the patient, the whole question of other relationships to her mother is indicated in her attitude of secrecy about such bastard babies.

Unlike her mother, she could not as yet consider letting the father of her fantasy babies know what she had taken from him. She would keep her impregnation a secret. She could only use a man, or rather his penis, for herself to have babies. In other words, the whole problem of her anxieties concerned with stealing the father's penis is indicated, with its deeper roots in her predatory wishes to take everything from the mother rival, who possesses everything, the father's penis and babies included. In view of this, it would seem very probable that there might be another especial significance for this patient in being named.

She believed she was a bad unacceptable

[2] *Psychiatric Quarterly*, October, 1948, **22**, 4.

bastard who had interfered with and damaged her parents by making them marry against their wish. Behind such beliefs, however, it would seem, are feelings that her parents were bad, threatening objects who had caused her to be a bastard. The feelings would then be projected feelings of her own sadistic wishes to destroy and separate the parents. Being named in the analysis might therefore necessitate disruption by her of such projection defence mechanisms, so that the real sadistic wishes would have to be looked at.

Rumpelstilzkin, a fairy story, as told by Grimm, has as its main point the matter of being named, and so seems relevant to the patient described. In it, a clever maiden is stated by her father to be capable of spinning straw into gold. She is brought to the king, and has to carry out this task, three times in all. Each time she is helped by a droll-looking little man to whom on the first two occasions she can give rewards he asks for. On the third, when she possesses nothing further, he asks for her future first-born. To this she agrees, and as a result of his efforts she becomes queen and later a mother. When the babe is born, the forfeit is demanded, but she pleads with her helper. He finally agrees to let her keep it if she can tell him his name within three days. Eventually she manages to do this—he reveals his name while dancing—and keeps her baby, the helper only being laughed at for taking all his trouble for nothing, whereupon he vanishes.

There can be little doubt that the droll-looking little man in the fairy story is the penis—the wonderful magician who can accomplish everything. But such a magical penis is also a dangerous one. Its results are uncertain, and even though it spins straw into gold and permits babies to be born, such gold and such babies may be taken away. In other words, it is both the good and the bad penis. Only when this is known, only when its bad part also is named, can one have control over the whole penis and use it constructively to make babies that live. Once the phantasied magical penis, the bad penis, Rumpelstilzkin, is named,[3] it vanishes.[4] Similarly then with the patient, being named might seem to mean for her that she is a real person, that Emily Standish with all her good and all her bad aspects is thus made known to the analyst, is understood by him. Therefore it could become possible for her really to speak of all her aspects, her good wishes and her bad wishes, with the fears and anxieties attached to them. Once consciously expressed and faced, it might be possible for the inhibiting anxieties to be resolved, to disappear, as happened to Rumpelstilzkin, who when named likewise had to vanish.

Freud has described analysis as a making conscious of the unconscious. In view of what has been said, it could also be considered as a naming of the unknown. The purpose of analytic work, then, if we continue the Rumpelstilzkin analogy, is to discover Rumpelstilzkin's name. How this may be done is the whole question of technique in analysis. In the fairy story itself, the actual discovery of the name is so rich in symbolic content and so similar to much of the patient's material that I quote it in full.

'The third day came back one of the messengers and said "I can hear of no other name; yesterday as I was climbing a high hill, where the fox and hare bid each other goodnight, I saw a little hut, and before the hut burnt a fire, and round about the fire danced a funny little man upon one leg and sang—

Merrily the feast I'll make, to-day I'll brew, to-morrow bake;
Merrily I'll dance and sing, for next day will a stranger bring;
Little does my lady dream Rumpelstilzkin is my name."'

Returning now to the patient, I wish to discuss certain aspects of the technique used to discover and name her conflicts. It was always clear that this patient, with her marked behaviour pattern of stimulating, similarly attempted to affect the analyst. Indeed in one sense the analyst responded to her stimulation when he spoke of the previous material which entered

[3] Rumpelstilzkin is a story in which naming something enables one to have power over it. An example of what we might call the antithesis of this is the tale of Odysseus and the Cyclops. (This point became available to me through Dr. Löbl.) In it Odysseus tells the Cyclops, Polyphemus, that his name is Nobody. Later when Odysseus and his men attacked the Cyclops so that he screamed, the other Cyclopes asked him what ailed him. He replied: 'It is Nobody's treachery, Nobody's violence, that is doing me to death.' Whereupon they answered: 'Polyphemus, you must be sick, and cannot be helped.' Thus Odysseus by not giving his real name but calling himself Nobody prevented Polyphemus from having any power over him.

[4] Considering the story in another way, Rumpelstilzkin is someone who cannot keep a secret. In other words, he cannot tolerate intense excitement to the full, but rather, just as the babe is about to become his and he is almost achieving his end, he reveals his secret, his name. He too, then, as it were ejaculates precociously.

his mind at the time, when there seemed to be almost an impasse regarding the second dream. Actually this was largely confirmed by work in the succeeding three months, when it became clear that the demand and behaviour of the patient at one level meant causing an erection of the penis. The work further showed that she wished to steal the erect penis. In the analytical situation the analyst's analytical power was then seen to be closely linked to the patient's fantasy of an erect powerful penis.

To respond in the sense described to a patient's demand may by many be considered unwise and liable to lead to too many complications. Dr. Heimann in her paper on Counter-transference (*Int. J. Psycho-Anal.*, 1950) refers to this, I think, when she speaks of the use an analyst may make of his counter-transference. I quote—' will protect him from entering as a co-actor on the scene when the patient re-enacts in the analytic situation '. In the case I have spoken of, the effect of responding, in the sense described, did not apparently interfere with further developments of the case. Indeed the feeling was that the case was enriched. The reason for this may have been that the analyst did not enter unknowingly as a co-actor. He knew he was reacting in the way he did. Moreover, before doing so, he had interpreted to the patient that she wanted him to do so. Also he had always had every intention of analysing the new situation that might arise as a result of such reacting.

Demands which a patient may make on the analyst may be handled in different ways. Balint [1] describes how ' at times, when the analytic work had advanced fairly deeply, patients expected and even demanded certain primitive gratifications, mainly from the analyst, but also from their environment '. Different ways of dealing with these demands, he found, produced different reactions in the patients, and from all this, in part, he has developed a theory of Primary Object Love. It would seem, then, that methods of handling patients' demands, at all levels of analytical work, are worth detailed consideration, and the method described in this case may perhaps be a contribution to this subject.

(It is to be noted that in most fairy wish-fulfilment tales—including *Rumpelstilzkin*—wishes (demands) are first granted magically. It is only afterwards that work may have to be done to retain the gifts.)

To summarize: Clinical material is presented in which occurred the naming of a patient by the analyst. The meaning of this naming to the patient is discussed and linked to the general purpose of psycho-analysis: a making known of the unknown, a revealing and naming of the unknown.

An attempt is made to understand the mode of discovering the unknown. The technique in this case was further linked to a basic pattern of behaviour of the patient, this very pattern being responded to in a certain way and the effect utilized to discover the patient's conflicts. The possible importance of different ways of handling the demands a patient may make on the analyst is touched upon.

(Received February 8, 1951.)

[1] Balint, M. *Int. J. Psycho-Anal.* 1949. ' Early Developmental States of the Ego. Primary Object Love.'

ORAL MECHANISMS IN CONSTIPATION AND DIARRHŒA[1]

By THOMAS S. SZASZ, M.D., Chicago, Illinois

Ever since the early works of Freud (13, 14, 16), Abraham (1, 2, 3, 4), and Ferenczi (10, 11, 12), a great many psycho-analytic observations have been reported concerning the normal activities and the dysfunctions of the upper (mouth and stomach) as well as of the lower (colon, rectum, anus) parts of the gastro-intestinal tract. In accordance with the theory of the development of the libido, and probably also because of the particular anatomical structures involved, upper gastro-intestinal disturbances have been generally interpreted in terms of ' oral regressions ', and lower digestive symptoms in terms of ' anal regressions '.

Psycho-analytic thinking concerning the excremental function and its disturbance has thus been dominated, in the past, by a certain type of approach to these phenomena, according to which disorders of the lower digestive tract were examined and interpreted from the point of view of the psychology of toilet training. Freud (14, 15, 17) had called attention to the psychological meaning of fæces and of defæcation to the infant, and he described the emotional implications of habit training and its effects upon character formation. It is not my intention to discuss in detail these well-established psycho-analytic concepts. I mention them only in passing in order to indicate the point of departure towards another approach to the study of lower gastro-intestinal disturbances which I would like to describe in this essay.

For a clear understanding of the problem of constipation and diarrhœa, we must first consider the precise physiological mechanisms responsible for these symptoms. The lower alimentary tract is divisible into two distinct functional areas, namely, the colon and rectum, which are regulated by the autonomic nervous system, and the external anal sphincter, which is under voluntary control in consequence of previous toilet training. Disorders of the colon and rectum express themselves either in increased secretion and motility resulting in diarrhœa, or in a decreased activity with a resulting constipation. Disorders of the anal sphincter are best analysed in terms that are also applicable to the vesical sphincter, viz. retention, frequency, and incontinence. Thus, constipation may be the result of an increased retention, and diarrhœa the result of an increased frequency.

In the past, little consideration has been given to the precise portions of the gastro-intestinal tract involved in these symptoms. Diarrhœa is thus usually interpreted to mean ' giving ' as a form of restitution, or eliminating in a hostile and destructive manner; and constipation is often interpreted as expressing a wish to withhold, to retain fæces as a valuable possession (5, 6). In other words, the physiological disorders are interpreted like hysterical conversion symptoms, i.e. as the symbolic expressions of unconscious psychological content. I believe that such formulations could be valid only for those cases of constipation and diarrhœa in which the symptom is due to a disorder of the external anal sphincter.

In this essay, I shall consider only those cases of constipation and diarrhœa in which the symptoms are based on a disordered activity of the colon and rectum. It is well established that in the syndromes of mucous colitis (21) and ulcerative colitis, constipation and diarrhœa are due to a colonic dysfunction; moreover, the symptoms in most cases of so-called functional, or psychogenic, constipation and diarrhœa are also due to such a mechanism (19, 20). The following case illustrates the effects of varying oral tensions (conflicts) upon lower gastro-intestinal functions.

* * * *

A young woman came for analysis because of a very severe depression and work inhibition. She also had many other distressing symptoms, the most important of which were an anorexic-bulimic eating disturbance and a complete amenorrhœa of approximately eight years'

[1] Read at the Annual Meeting of the American Psychoanalytic Association, Detroit, April 28, 1950.

duration. A detailed account of her personality development and of her illness, as reconstructed in a long analysis, is not relevant for our present purpose.

The patient's nuclear difficulty lay in her intensely ambivalent oral-sadistic attachment to her mother. This early conflict had never been mastered by the patient with any degree of success. Throughout her entire life, from the time she was weaned from the breast onward, the patient had had some type of symptom related either to her eating habits or to the gastro-intestinal tract. Her personality development was later complicated by an extremely intense œdipus conflict; more precisely, she developed an intense erotic attachment to her father and younger brother. This was brought about partly by the father's seductive attitude towards the patient as a child, to whom he turned from his frustrated and painful relationship with his wife. Corresponding with this passionate attachment to the father, the patient developed an equally intense fear of the mother. There thus resulted a profound inhibition of psychosexual maturation: psychologically, sexuality was deeply repressed; and physiologically there resulted a state which could only be interpreted as due to the absence of the stimulating effects of the female sex hormones. The uterus and breasts were undeveloped, and menstruation did not occur. (The patient started to menstruate at fourteen and continued to have irregular cycles for approximately two years; following this a complete amenorrhœa developed which was refractory to several attempts at endocrine treatment.)

It is important to note that because of an unusually strong fixation at an oral level, this patient was very prone to regress to this early conflict with the mother, and she thus developed various oral-regressive symptoms in response to a wide variety of stimuli (conflicts).

The most crucial precipitating factor in the patient's initial depression which brought her to analysis was her separation from her mother. In addition to the severe depression, she also developed a bulimic eating disturbance. (Bulimia appeared for the first time when the patient was sixteen years old, and simultaneously her menses ceased.) This symptom persisted for many months during the initial phases of the analysis and recurred frequently thereafter. *Attacks of bulimia were invariably accompanied by severe constipation.* Bulimic eating was brought on, according to the patient, not so much by a sensation of hunger, but rather by certain specific feelings which were referred to the stomach and which often seemed clinically indistinguishable from somatic delusions. The patient would thus complain of 'cutting pains' in the stomach, of feeling as if knives were being turned round inside her, or of 'having to eat to put out the fire inside'; the latter was the most frequently recurring description of these sensations. Accordingly, the patient usually had a craving, at such times, for what she called 'soothing foods', such as jelly, puddings, and other semi-solid foods. Following such 'eating orgies', she would feel 'bloated' and constipated. Often she took several enemas after an episode of overeating.

In the course of the analysis, the patient developed a very intense transference neurosis. For the first several months, the patient was seen daily, and later four to five times a week. This meant to her, both consciously and unconsciously, that she was 'given enough'. Her bulimia was largely relieved, and concurrently her chronic constipation gave way to 'normal' bowel habits (i.e. approximately one formed stool a day, passed without much effort).

During the later stages of the analysis, changes in the transference situation—whether brought about more or less fortuitously by external circumstances, or by the analyst's interpretations—were usually accompanied by dramatic changes in the patient's gastro-intestinal functions. It was thus possible to make rather accurate correlations between certain changes in the transference on the one hand, and the patient's gastro-intestinal symptoms on the other; and these correlations gained in validity by repetitions of similar changes in the transference and in the patient's physiological reactions, during the repetitive 'working through' of essentially the same conflicts over extended periods of time.

After approximately two years of analysis, severe bulimic (or anorexic) attacks no longer occurred and her weight was well stabilized. (During early phases of treatment, she sometimes gained more than ten pounds in weight within a week.) There were even more profound changes in her endocrine physiology. A regular menstrual cycle was now established and the patient developed normal secondary sex characteristics.

The most important feature of her transference attitude, at this time, was her unyielding

possessiveness. This, indeed, characterized her relationship towards both her parents, and the mother-and-father-transference fused, so to speak, in this common denominator. As this problem came to a focus in the analysis, the patient developed *severe pains in the jaws.* The pain was localized in both masseter muscles and in the region of the insertion of these muscles into the mandibles; the pain was often present for long periods of time (weeks), at other times was more evanescent, and frequently it was present upon awakening from sleep. At times it was completely relieved by masturbation. Analysis of this symptom revealed it to be highly over-determined psychologically. It represented, primarily, the wish (and its inhibition) to possess the father completely by incorporating his penis, as well as the wish to possess the mother by incorporating her breast; at both of these levels it was directed towards the analyst. The pain often disappeared when the patient came to the analytic hour.

As mentioned, this symptom appeared and disappeared many times during the analysis. *Each time it was accompanied by a change in the patient's bowel habits in the direction of constipation.* A characteristic situation, for example, was related by the patient in the 298th hour. This session took place a few days before a Christmas vacation was to interrupt the analysis for about two weeks. Anticipating this, the patient became very depressed and bulimic, developed the pain in the jaws mentioned above, and at the same time she also became constipated. Giving herself an enema relieved not only her feeling of constipation, but eased the depression and psychic tension as well.

It was clear that this patient regressed with great readiness from a sexual (genital) conflict or activity to an oral (gastro-intestinal) one. At the same time, oral (gastro-intestinal) activities became sexualized beyond their original infantile-erotic content. This is strikingly illustrated by a dream reported in the 318th hour. The following is only the last part of a longer dream:

'. . . In another scene I had my green wool gloves on my hands. I experienced very unusually satisfying sexual feelings. The feelings came from masturbating. I thought I was masturbating and was surprised to wake up and find that I was dreaming. I never experienced that feeling outside a dream. Before the sexual dream, I was agonizingly hungry in the dream and decided to get some food. After masturbating, the hunger went away.'

This dream illustrates the unconscious meaning and motivation of the patient's bulimia: the pathologically increased and persistent 'hunger' originated not from a biological need for food, but from unsatisfied sexual urges.

Other events of interest occurred at a still later stage of the therapy, when the most deeply oral, incorporative meaning of the analytic situation was analysed. In the 375th hour, the patient complained again of pain in the jaws during the preceding twenty-four hours. This was again related to her sexual impulses towards the analyst which, in turn, she now associated with her erotic feelings for one of her brothers. It was clear, as indeed it had been clear for a long time to the analyst—without, however, his succeeding in *effectively* interpreting this to the patient—that coming to the analytic sessions, lying on the couch, hearing the analyst speak, etc., represented to the patient a satisfaction, in a disguised form, of her erotic demands from the analyst.

The patient was next seen three days later. The pain in the jaws and the constipation had continued until just one hour before the analytic session, when she had several loose bowel movements. During the preceding three days she was not only constipated but felt as if her constricted bowels were in her throat; she would go to the toilet in an attempt to defæcate but was unsuccessful.

In this and some subsequent hours, it finally became possible to *interpret effectively* to the patient that the analysis represented a direct gratification of her oral as well as her sexual demands on the analyst. She recalled, in this connexion, how, when sleeping in the same room with her brother, she just 'loved to talk to him' and would engage him in interminable conversations before going to sleep. *The pain in the jaws and the constipation disappeared once more.* The most dramatic development, however, occurred about a week later (379th hour) when the patient smoked for the first time in her analytic sessions, up to this date (approximately two and one-half years). Although a heavy smoker, she had always extinguished her cigarette before beginning the hour; on this day she sat on the couch and asked permission to smoke. It was clear that the previous interpretations had made it impossible for the patient—at least, to some degree—to continue to regard (unconsciously) the analysis as a situation in which she was, so to speak, being fed by the analyst's words. The

oral tensions, previously relieved by the analytic situation itself, were now appeased, in part, by smoking.

Another series of events that occurred about two weeks after the hours just described illustrates further the manner in which oral tensions influence lower bowel activity.

In the meantime, the patient had met a young man to whom she was much attracted and who, in turn, seemed to show considerable interest in her. These events served as strong stimuli for her wishes to become more feminine in order to strengthen this man's interest in her. However, such impulses tended to mobilize much anxiety, as her ambivalence towards her mother made identification with her very difficult. Also, the mother's illness always loomed in the background, as a kind of punishment for her (i.e. for the mother's) destructive (feminine) sexuality (towards the father). (The mother had developed a serious illness following the death of her husband, when the patient was nineteen years of age, and recovered from this only after a long period of disability.) She now speculated about her wishes for a woman analyst, being conscious at the same time of her immense fears of being treated by a woman. She again developed a pain in her jaws. In the 384th hour, she had a dream which related directly to her mother's illness. Two hours later (386th hour), she reported the following dream:

' Two women lying down, with big, sagging breasts, very voluptuous-looking. Fat women with big breasts. I heard a voice in the dream saying, " You are so unhappy. . . ." '

Much important material emerged in this and several subsequent hours relative to this dream. Her associations first centred around her belief that her boy friend was interested in her body only. To be a woman meant to have breasts; to be fat (pregnant) and to have large breasts meant an intensification of feminine sexuality and referred to being like mother. It is important that although the breasts in the dream were described as ' sagging ', she felt they were ' voluptuous '.

The analysis of the dream was continued in the next hour. The two women in the dream were naked, were lying side by side and *looked identical*; both were about forty years old. The patient then recalled memories from her early teens (about twelve or thirteen) of how father wanted to have intercourse with mother, mother refusing and patient then crawling into mother's bed, to be sure that mother would not give in. She was conscious of her admiration for her mother's physical beauty, particularly her breasts. The intense homosexual tie to the mother thus came to the fore. *Parallel with these feelings and phantasies, she again became constipated.*

In the next hour (the 388th), she continued to complain of pain in the jaws and was constipated. The oral-destructive, cannibalistic aspect of her relationship to her mother was once more pointed out. The dream was interpreted as meaning that the desire to be like someone else (like mother) meant to her the incorporation of the object *in toto*—hence the exact likeness of the two people in the dream. This was made much more vivid by the patient having expressed similar feelings with regard to the analyst's intellect which she admired just as she had at one time admired her mother's breast. Thus, *both* the transference and its infantile basis were interpreted. The patient then revealed that she had actually been much worried by a decrease in the size of her breasts over the last week or so, in spite of the fact that she had not lost any weight; and she added that she was now deliberately trying to eat more with the conscious fantasy that ' the food will go into my breasts ' and will make them larger.

The following morning, the patient awoke from a long dream at 6.00 a.m. and had a loose bowel movement; an hour later, she had another loose stool. The dream of the preceding night was long and complex. The outstanding features of the dream were that in each scene there was much dirt; in one scene, she lay with her breasts exposed in the presence of her favourite brother, a male physician, a female physician, and her mother, and there was a question of whether or not she could marry a doctor.

* * * *

These observations, and numerous similar events which occurred in the course of this patient's analysis, left little doubt that changes in colonic activity (i.e. constipation and diarrhœa) were brought about by certain changes in oral tensions. I want to emphasize in this connexion that from among the various facets of the foregoing clinical material [2] I wish to

[2] Similar cases of bulimia were described by M. Wulff (22) and Therese Benedek (7); excellent discussions of the psychological origins and significance of this symptom-complex are to be found in these two papers.

focus upon only one aspect of the data, namely, upon the variations in the activation or inhibition of the patient's oral-incorporative tendencies and the concomitant changes in colonic activity.

It was seen that constipation occurred regularly at first during episodes of bulimia, and later during attacks of pain in the jaws. The unconscious instinctual content of these symptoms (i.e. of the bulimia and the pain in the jaws) consists of an insatiable oral-incorporative need. On the other hand, we could see time and again how satisfaction, or anticipation of satisfaction, of the oral-intaking needs would result in immediate disappearance of constipation and sometimes in diarrhœa. Illustrative of this is the occurrence of diarrhœa just preceding an analytic session. Further, the last series of events described (i.e. events following the 384th hour) showed once more how the mobilization of an intense mother-transference, and specifically of cannibalistic phantasies concerning the mother (and analyst), was accompanied by a change in bowel function in the direction of marked constipation. Effective interpretation of this material was followed within twelve hours by an attack of diarrhœa. The mechanism underlying this change, I believe, consisted primarily in a sudden *inhibition* of the oral-incorporative drive because of *guilt*. The patient actually reacted (unconsciously) to the analyst's comments regarding the wish to incorporate the mother (and the analyst) as if he had said: 'You are bad. You should not behave in this way.' The dream of the following night deals with her *giving* her breast to persons who represent the mother and the analyst.

Summarizing these observations, we can state that in this patient activation of unconscious oral-incorporative tendencies was accompanied by a tendency towards constipation; whereas anticipation of satisfaction, actual (including symbolic) satisfaction, or inhibition (because of guilt) of the oral-incorporative drive regularly resulted in a tendency towards increased colonic activity as shown by relief of constipation or diarrhœa. Numerous similar correlations between varying activation and inhibition or oral-intaking impulses and colonic function were observed during the analysis of several other patients. Noteworthy among these is the case of a man with ulcerative colitis. This patient showed a most interesting alternation during various periods of his life between symptoms of peptic ulcer and ulcerative colitis; the two syndromes, however, never occurred at the same time. Analysis of this patient revealed that his nuclear conflict centred around unconscious, magically-destructive, oral-sadistic impulses and phantasies; whenever these tendencies were mobilized (e.g. by his marriage), his ego made desperate attempts at a defence against them; inhibition (because of guilt) of the oral-incorporative drives would thus ensue, and in this situation the patient would develop diarrhœa. When, in the course of analysis, the guilt over and thus the inhibition of the oral-incorporative impulses was diminished, not only did the ulcerative colitis disappear, but the patient became constipated and developed typical ulcer symptoms.

The question now arises how oral tensions can influence lower gastro-intestinal activity. For an understanding of this problem, we must turn our attention once more to some physiological considerations.

* * * *

The physiological interrelations between the upper and lower portions of the digestive tract will be summarized here briefly. A more detailed discussion of this subject will appear in the near future (20).

In the infant, or in undomesticated animals, defæcation occurs in a definite pattern: *the nursing infant experiences hunger, feeds, then defæcates and falls asleep.* This is the basic rhythm of the gastro-intestinal tract. Filling of the stomach leads to peristaltic movements of the colon and rectum and to defæcation (the gastro-colic reflex) (9, 18, 23). I believe that our understanding of constipation and diarrhœa must be based upon this fundamental pattern of gastro-intestinal activity. The normal impulse for defæcation is thus not a conscious or deliberate one, but results from an activation, due to parasympathetic stimulation, of the colon and rectum. Accordingly, just as we cannot consciously decide when to become hungry, although we can postpone or otherwise deliberately regulate the satisfaction of this need, similarly we cannot control the activities of our colon. In habit training, all that is accomplished is that the external anal sphincter, which consists of striped muscles and is supplied by fibres from the cerebrospinal nervous system, is brought under voluntary control. Toilet training is thus essentially an inhibitory function: we are taught when *not* to defæcate, rather than when to do so.

The effects of vagotomy, performed for the treatment of duodenal ulcers, throw further light on this subject (19). Ulcer patients are frequently constipated; following vagotomy, however, a large percentage of patients (50–75 per cent) experience some degree of change in bowel function in the direction of looser and more frequent movements. Occasionally, severe diarrhœa develops following this operation. These phenomena appear to be consistent with what we have described as the basic pattern of gastro-intestinal activity. In other words, it appears that there exists a reciprocal relationship between the activities of the upper and lower portions of the digestive tract. More specifically, during periods of hunger, i.e. during excitation of the vagi, the colon and rectum are inhibited; this may be due to inhibition of the sacral parasympathetics supplying the colon and rectum, or to sympathetic stimulation of these organs. Conversely, inhibition of the vagi (or sympathetic stimulation of the stomach and duodenum) results in activation, due to parasympathetic stimulation, of the colon and rectum. *The gastro-colic reflex is the normal prototype of this interrelationship between upper and lower digestive activity.* Filling of the stomach satisfies the oral-incorporative need and results in a diminished vagal tonus; activation of the colon and rectum and defæcation follow. Vagotomy, in a sense, simulates a condition of the stomach which is like that occurring after feeding; this is thought to be the basic mechanism responsible for the changed bowel function of vagotomized patients.

We may now return to our psycho-analytic material. A comment upon the method employed in interpreting the psycho-analytic data presented is perhaps in order. First, it was necessary to ascertain the nature of the predominant instinctual (libidinal) impulse with which the patient was struggling (e.g. whether oral, anal, urethral, genital); second, in the case of the oral-incorporative drive, with which we were concerned in this essay, it was necessary to know the approximate intensity of the drive and to what extent it was active or inhibited. Finally, we have to *extrapolate* the neuro-physiological status of the patient's upper digestive tract from the psycho-analytic material. This procedure seems permissible in view of our considerable knowledge, from various sources, concerning the psychology and physiology of the gastro-intestinal tract. At the same time, this methodological approach is not only permissible, but necessary, if we are to advance in our understanding of these problems. If we rely upon psychological material alone, then we are in danger of confusing the secondary psychological elaborations of a physiological dysfunction with the more primary, etiologically motivating emotional factors. It is thus one of the aims of this paper to demonstrate that what may appear as 'anal material' in the analysis of certain cases of constipation and diarrhœa may be entirely a secondary psychological elaboration of the disturbed colonic function and may have no causal relationship with it.

* * * *

Summary

Psycho-analytic observations in a case of anorexic-bulimic eating disturbance showed that during periods of bulimia the patient was constipated. Significantly, eating, even large quantities of food, did not relieve the constipation; this is consistent with the fact that eating does not actually lead to *satiation* in such cases, since the powerful oral-incorporative tendencies are not motivated by a biological need for food. Accordingly, we postulate a persistent vagal excitation in the patient, during such periods, and this in turn leads to inhibition of colonic and rectal activity, and finally to constipation. When the intaking needs were satisfied in the transference situation, the constipation disappeared. The interpersonal relationship in the analysis affected the patient's gastric functions as food affects the stomach of the infant, with a resulting feeling of satisfaction and decreased vagal activity which, in turn, leads to parasympathetic stimulation of the colon and rectum, and to defæcation. Finally, in a patient with ulcerative colitis, attacks of diarrhœa could be traced to an intense inhibition, on account of guilt, of powerful oral-sadistic (cannibalistic) tendencies; this psychological 'inhibition' is postulated to be paralleled by an inhibition of the vagi and thus, through the chain of events described above, diarrhœa results.[3]

[3] For a striking illustration of the probable role of this mechanism in the psychogenesis of severe diarrhœa, see Bernhard Berliner's paper, 'The Psychogenesis of a Fatal Organic Disease' (8). Berliner describes the case of a woman suffering from a 'dysentery-like colitis' (severe bloody diarrhœa); I believe one may venture to

The foregoing considerations are proposed as a new theory of the psychogenesis of constipation and diarrhœa due to colonic dysfunction. *According to this theory, the symptoms do not express any primary psychological meaning, but are interpreted as manifestations of a vegetative (organ) neurosis, i.e. as the remote physiological sequelæ of oral tensions.*[4]

[Received October 20, 1950]

REFERENCES

(1) Abraham, K. (1916). 'The First Pregenital Stage of the Libido', *Selected Papers*. London: Hogarth Press, 1948.

(2) —— (1917). 'The Spending of Money in Anxiety States'. *Ibid.*

(3) —— (1920). 'The Narcissistic Evaluation of Excretory Processes in Dreams and Neurosis'. *Ibid.*

(4) —— (1921). 'Contributions to the Theory of the Anal Character'. *Ibid.*

(5) Alexander, F. (1934). 'The Influence of Psychologic Factors upon Gastro-intestinal Disturbances: A Symposium. I. General Principles, Objectives and Preliminary results', *Psychoanalyt. Quart.*, **3.**

(6) —— (1941). 'Gastrointestinal Neuroses'. In Portis, S. A.: *Diseases of the Digestive System*, Ch. vi, pp. 206–226. Philadelphia: Lea and Febiger.

(7) Benedek, Therese (1936). 'Dominant Ideas and their Relation to Morbid Cravings', *Int. J. Psycho.-Anal.*, **17.**

(8) Berliner, B. (1938). 'The Psychogenesis of a Fatal Organic Disease', *Psychoanalyt. Quart.*, **7.**

(9) Best, C. H. and Taylor, N. B. (1939). *The Physiological Basis of Medical Practice*, pp. 810–820. Baltimore: Williams and Wilkins Co.

(10) Ferenczi, S. (1914). 'The Ontogenesis of the Interest in Money', *Sex in Psychoanalysis*. New York: Basic Books, 1950.

(11) —— (1919). 'The Phenomena of Hysterical Materialization'. In *Further Contributions to the Theory and Technique of Psychoanalysis*. New York: Boni and Liveright, 1927.

(12) —— (1925). 'Psycho-analysis of Sexual Habits'. *Ibid.*

(13) Freud, S. (1905). 'Three Contributions to the Theory of Sex', *The Basic Writings of Sigmund Freud*. New York: Random House, 1938.

(14) —— (1908). 'Character and Anal Erotism', *Collected Papers*, **2.**

(15) —— (1909). 'Analysis of a Phobia in a Five-year-old Boy', *Collected Papers*, **3.**

(16) —— (1918). 'Anal Erotism and the Castration Complex' in 'From the history of an infantile neurosis', *Collected Papers*, **3**, p. 548. London: Hogarth Press, 1948.

(17) —— (1933). *New Introductory Lectures on Psychoanalysis*. New York: W. W. Norton.

(18) Hertz, A. F. and Newton, A. (1913). 'The Normal Movements of the Colon in Man', *J. Physiol.*, **47.**

(19) Szasz, T. S. 'Psychiatric Aspects of Vagotomy: III. The Problem of Diarrhea after

---

assume that this patient suffered from a fulminating case of so-called non-specific ulcerative colitis. Impressive in the case material cited is the deep oral regression of the patient as well as an apparent correlation between the inhibition of oral-sadistic (cannibalistic) tendencies and an exacerbation of the diarrhœa.

[4] It should be noted, however, that the theory proposed in this paper does not exclude the possibility that eliminative and retentive (i.e. anal-erotic) tendencies may influence colonic activity; but, whereas the nature of such psychological tendencies (i.e. anal-erotic drives) is well understood, the precise physiological mechanisms whereby emotional processes of this type could affect the regulation of the colon and rectum remain to be elucidated.

In this paper, we were concerned only with those mechanisms, physiological as well as psychological, which could influence colonic activity *from above* (i.e. vagal tonus and 'oral' mechanisms). There is no implication in this theory that this type of mechanism is the *only* one which can affect colonic function. Indeed, there is evidence to suggest that the autonomic regulation of the lower digestive tract may be influenced not only from above, but also *from below*, i.e. from the anus. Illustrative of this is the common practice of nurses to insert a suppository, or in other ways to stimulate the anus of infants, and thus to stimulate an evacuation (i.e. stimulate colonic and rectal activity). Physiologists have shown, moreover, that anorectal stimulation causes a complete inhibition of gastric hunger contractions in the dog (23, p. 38). This suggests the possibility that such inhibition of upper gastro-intestinal activity in turn activates the gastro-colic reflex and thus causes defæcation. Whether this is the physiological mechanism involved in the stimulation of colonic activity by anal manipulations, or whether some other mechanism is involved, it is clear that there exist physiological pathways through which *anal* tendencies may also affect colonic and rectal function. Accordingly, in addition to the oral mechanisms in constipation and diarrhœa described in this paper, one would have to work out the *anal mechanisms* involved in these syndromes. It should be noted, however, that the term 'anal mechanism' refers to an *organ-neurotic chain of events*, and not to conversion symptoms affecting the anal sphincter. In other words, the symptom of diarrhœa, for example, even if brought about by an anal mechanism, would not express any primary psychological meaning, but would have to be understood in terms of a chain of physiological events; the first link in such a chain would be an *anal stimulus* (anal-erotic impulse) and only this first link would have a causal psychological meaning.

Vagotomy', *J. Nerv. and Ment. Dis.* To be published.

(20) —— (1951), 'Physiologic and Psychodynamic Mechanisms in Constipation and Diarrhea', *Psychosom. Med.*, **13.**

(21) WHITE, B. V., COBB, S., and JONES, C. M. (1939). *Mucous Colitis: A Psychological and Medical Study of Sixty Cases.* Psychosom. Med. Monograph No. 1, Washington, D.C.: National Research Council.

(22) WULFF, M. (1932). 'Über einen interessanten oralen Symptomenkomplex und seine Beziehung zur Sucht', *Int. Z. f. Psychoanal.*, **18.**

(23) YOUMANS, W. B. (1949). *Nervous and Neurohumoral Regulation of Intestinal Motility*, Chapter xvi. New York: Interscience Publishers.

SIGMUND FREUD, M.D., 1882—1885

By SIEGFRIED BERNFELD, PH.D., SAN FRANCISCO, CAL.

I. MEDICAL STUDIES

Freud summarized his attitude towards medical practice in a little known passage in the 'Postscript to a Discussion on Lay Analysis'. 'After forty-one years of medical activity', he said, 'my self-knowledge tells me that I have never really been a doctor in the proper sense. I became a doctor through being compelled to deviate from my original purpose. . . . I have no knowledge of having had any craving in my childhood to succour suffering humanity. My innate sadistic disposition was not a very strong one, so that I had no need to develop this one of its derivatives. Nor did I ever play the "doctor game"; my infantile curiosity evidently chose other paths . . . I scarcely think, however, that my lack of genuine medical temperament has done much damage to my patients. For it is not greatly to the advantage of patients if their physician's therapeutic interest has too marked an emotional emphasis. They are best helped if he carries out his task coolly and, so far as possible, with precision' (Freud (16), p. 208).

Freud's family early sensed this 'lack of genuine medical temperament'. 'He is too soft-hearted; he cannot stand the sight of blood', (Bernays (1), p. 340) was their way of expressing it when, at seventeen, he announced the sudden reversal of his plans. Instead of taking up law he had decided to study medicine. His father and sister, of course, shared the current ideal of the physician as a man who had to be enthusiastic in helping the sick and ailing and, at the same time, hard and insensible to their wounds, deformities, pains and suffering. Freud had decided to study medicine with the vague but overwhelming desire of penetrating into the mysteries of nature rather than with any clear concept of ever becoming a practising physician. Medicine to him was the practical way of realizing his intense curiosity in nature and human relations, and his ambition to contribute —perhaps—to the solution of some of their riddles. From his various autobiographical remarks we gather only that he was slow and negligent in his medical studies, and inclined to drift into intense preoccupations with fields far from the practical way. Now thanks to the successful efforts of Professor Viktor Kraft in Vienna, who has at my suggestion searched the archives of the Vienna University, we can follow Freud step by step through the zig-zag of his university years.[1]

The academic year at the University of Vienna was divided in two; the winter term running from October to March and the summer term from the end of April to the end of July. Freud—seventeen and a half years old—registered in the *Medizinische Fakultät* in the winter term 1873–74 and enrolled, as a regular medical student was supposed to, in classes in anatomy and chemistry. Altogether he signed up for twenty-three hours a week, including work on anatomic dissections and in the chemistry laboratory. During his first summer semester (1874) he spent twenty-eight hours weekly in anatomy, chemistry, microscopy, biology and mineralogy. He added, as an intellectual luxury, a course on 'Biology and Darwinism' by the zoologist Claus, and Brücke's lectures 'On the Physiology of Voice and Language'. In the winter term of his second year (1874–75) he still worked like a studious future physician—twenty-eight hours weekly—on anatomical dissections, zoology, physics and physiology. Once a week, however, he permitted himself a glance at philosophy in Brentano's reading seminar.

Suddenly in the summer term of 1875 we find Freud guided by his preferences alone. He had switched from 'zoology for medical students' to zoology proper (fifteen hours with Claus). He took two physics classes; more than was required by the medical curriculum. He not only continued the philosophy seminar, but also added Brentano's class on Aristotle. He continued with the physiology

[1] See Appendix: Complete list of classes in which Freud registered.

lectures and laboratory rather because of his growing attachment to Brücke than in obedience to the medical curriculum.[2] Freud has this term in mind when he recalls in 1899 that he was ' immersed completely in books ', and that his family applied some pressure to make him exchange ' abstruse studies for something more practical. But when it became apparent how set my intentions were the plan was dropped ' (Freud (11), p. 60).[3]

In his third year (1875–76) Freud appears to have completed the shift from medicine to biology. Most of his time is spent on advanced work in the Zoological Institute; during March and September he works in the Marine Zoological Station at Trieste on a research assignment concerning the testes of the eel. He takes a course in plant physiology, works in Brücke's physiology laboratory, enrolls in the seminars and classes of Brücke's assistants Exner and Fleischl, on nerve physiology and spectral analysis, and also continues with philosophy. During the summer he resumes anatomic dissections—possibly an indication that he had reminded himself of his previous plans, but more probably because they were a part of his biological interests. In the autumn of 1876, or perhaps as early as the summer, he formally joins the Institute of Brücke as a *famulus* (research student) and starts his work on the histology of the nervous system, which he was to continue until 1882.

' During my first three years at the University,' says Freud (15, p. 15), ' I was compelled to make the discovery that the peculiarities and limitations of my gifts denied me all success in many of the departments of science into which my youthful eagerness had plunged me. Thus I learned the truth of Mephistopheles' warning: " It is in vain that you range around from science to science; each man learns only what he can learn." At length in Ernst Brücke's Physiology Laboratory I found rest and satisfaction—and men, too, whom I could respect and take as my models; the great Brücke himself and his assistants, Sigmund Exner and Ernst von Fleischl.' The ' rest and satisfaction ' that he thus finally found in Brücke's Institute enabled him simultaneously with his work there, so it seems, to resume in an orderly and concentrated manner his medical studies after a lapse of three semesters. In the fourth winter term (1876–77) we find him busy for thirty hours a week with pathology, pathological anatomy, surgical and medical clinics. For an additional eight hours he worked with Fleischl and Exner at higher mathematics and physiological topics, and for good measure, he enrolled in a short course on the effects of poisons. Freud stuck to it. From then on, with the exception of a short course by Fleischl on ' Muscle and Nerve Physiology ', his schedule contains for four semesters—until 1878—merely the essential medical topics, up to forty-one hours a week.[4]

In 1878 Freud, in addition to his crowded medical schedule, spent a summer term and a portion of his summer vacation in physiological animal experimentation in Stricker's laboratory. He writes to his life-long friend of his gymnasium years, Wilhelm Knöpfmacher (August 6, 1878): ' . . . I have enrolled in another laboratory. Here I am preparing myself for my real profession, to torture animals or to torment people. I come to favour more and more the first term of this alternative ' (Freud (17), p. 21). In the research project that was assigned to him in Stricker's Institute, he failed.

During these years of medical study most of the men with whom Freud worked were excellent and stimulating teachers. Some, like Billroth, Hebra, and Arlt were world-famous and attracted large crowds of admiring and enthusiastic students. They gave more than the routine, standard knowledge of contemporary medicine. They were brilliant innovators in their fields and instilled into their students the spirit of scientific medicine. They made them love their profession and be proud of it—even unduly proud. Yet Freud remained very cool to them and their work. At the end of this period he was still not interested in any one of the medical specialities with the exception of Meynert's psychiatry. He thought of himself as a future physician with little respect and less pleasure; he even doubted seriously whether he would ever want to become one, as the letter to Knöpfmacher proves. Neither was physiological research—' to torture animals '—his

---

[2] Ernst von Brücke's Institute of Physiology was the centre of basic research in biology, including biochemistry and biophysics. Although Brücke's classes and laboratory courses were a part of the medical curriculum, little attention was given to any medical application of the research accomplished there. For information on Brücke, his Institute and Freud's work there see Bernfeld (3), p. 10 *ff.*

[3] For justification of the identification of the ' man 38 years of age ' with Freud see Bernfeld (2).

[4] The complete list of the classes in which Freud was enrolled is to be found in the appendix.

choice at that time. In fact, he remained at the peaceful occupation of histological research in Brücke's Institute.

After five years of study the average medical student was ready for the required three comprehensive examinations (*rigorosa*). Freud, however, was not quite ready. In spite of his lack of interest in and some aversion to medicine, he completed his curriculum through an additional winter term (1878–79) with Bamberger's Internal Medicine and Arlt's Ophthalmology—ten hours weekly. Then, in the summer of 1879, he started in Brücke's Institute the investigation of the nerve cells of the crayfish and published his new histological method, calling himself proudly in the by-line, Drd. Med. (*doctorandus medicinæ*). However, he still did not take his examination. He was in no hurry to graduate. A full year passed—'My acquaintances regarded me as a loafer and doubted whether I would get through. Then suddenly I decided to take my examinations and I "got through" in spite of the "postponement"' (12, p. 9).

With the scantiest of preparation and—as he says—a well-justified fear he faced, on June 9, 1880, his friend Fleischl as examiner for the first *rigorosum* in botany, biology and chemistry. 'I escaped disaster through the clemency of fate or of the examiner' (12, p. 317). He received, in fact, the grading 'excellent'.[5]

On the same day in the second *rigorosum* on medicine in general, Hoffman passed him as 'satisfactory' only because Freud had failed in forensic medicine. Freud worked in Brücke's laboratory another ten months before he stood for the third *rigorosum* on the several medical specialities. Hoffman was again the examiner and passed him, on March 30, 1881, with the grading 'excellent'. This result, according to Freud, was due only to the photographic memory that he had enjoyed all through his childhood and adolescence, although it was gradually becoming unreliable. He had not used the long interval for preparation for the examination, but 'In the tension before the final medical examination I must have made use of the remnant of this ability, for in certain subjects I gave the examiners apparently automatic answers which proved to be exact reproductions of the text-book which I had skimmed through but once, and then in greatest haste' (14, p. 96). Thus his M.D. degree is dated March 31, 1881. The graduation ceremonies took place in the beautiful aula of the baroque building of the old university. Freud's family were present, and Richard Fluss with his parents, old friends of his early childhood years in Freiberg, Moravia.

In Freud's own words, this third and final medical examination was not taken with any practical purpose in mind. It did serve to reassure his self-esteem which had seemed threatened by the criticism and scepticism of his acquaintances. It was a purely psychological incident and did not interrupt his histological work. He had paid homage and tribute to the reality principle. He had proved that he could learn medical texts but was not willing to torment mankind. He continued work at Brücke's Institute more intensely than before. Brücke promoted him to the position of demonstrator, the equivalent to our teaching assistant, and he served in this position from May, 1881, to the end of June, 1882—three university terms. Simultaneously he occupied a laboratory place for advanced chemical work in gas analysis, in Ludwig's Chemical Institute, which shows that he intended to expand from histology to physiological research along the lines that both Brücke and Meynert favoured. Then with another of these sharp turns of his life path, in the summer of 1882, more than a year after graduation, he decided to earn his livelihood as a physician and left Brücke's Institute.

II. The Turning Point

Of this decision, most influential in the course of his life and his work, Freud says in the *Autobiography*, 1925: 'The turning point came in 1882 when my teacher, for whom I felt the highest possible esteem, corrected my father's generous improvidence by strongly advising me, in view of my bad financial position, to abandon my theoretical career. I followed his advice, left the physiology laboratory and entered the General Hospital' (15, p. 16). One year later, he gives substantially the same presentation in another place: '. . . till the teacher, whom I so deeply respected, warned me that in view of my restricted material circumstances I could not possibly take up a theoretical career' (16, p. 208). To a remark of Wittels that Freud broke with Brücke, he

[5] It is probably this examination to which he refers in his associations to the 'Dream of a Botanical Monograph'. 'At my preliminary examination in botany I was required to identify a crucifer and failed to recognize it; had not my theoretical knowledge come to my aid I should have fared badly indeed.' (12, p. 242).

commented: 'In 1882 I had left the physiological laboratory on Brücke's advice.' [6]

These various carefully phrased autobiographical statements leave the reader somewhat mystified. Only one thing seems clear, that Freud was not forced out of the Institute by Brücke, but that he left of his own accord with Brücke's friendly consent. Yet it was a forced choice, a reluctant submission by Freud to an adverse economic reality. But why had Freud suddenly to submit his research interests that had dominated him so strongly and exclusively for six years, for which he was so clearly gifted and in which he was more than moderately successful? Scores of young scientists without means before and after him have refused such an opportunist choice, and have had little reason to regret their insistence at the end of their lives. Or, viewed from a different angle, why had Freud indulged so long in an illusionary 'escapist' attitude? Why had he spent so many years on a career that was not for him? Freud gives no answer to these questions. However, when we survey the entire situation as it existed in 1882—although we know little of its complex details—one of the noteworthy factors becomes clear enough.

Freud's father at sixty-seven—though in uncertain financial circumstances, dependent at times upon loans and gifts from his wife's relatives, burdened with a family of seven children—was still continuing fully to support his eldest son, then twenty-six years old. He did it graciously, generously and willingly with that improvidence that distinguished him. He had given his son full freedom of vocational choice and was quite ready to carry him through medical school. While Freud was going through his chaotic period, during his first years at the University, his father worried about his future and made plans to induce him to go into business and to marry his niece. But he soon gave up, and though he may have wondered from time to time what the final outcome would be he had not objected when Freud took eight instead of five years in which to get his medical degree. When even then Freud showed no inclination to earn money as a doctor but chose to continue as a research histologist in Brücke's Institute, the father was certainly proud of his intellectual distinction and probably well satisfied with the complete lack of business sense in his son—a trait that he himself did not possess and that ranked pretty low in his own private philosophy of values. He never thought of forcing his son into a more profitable occupation. And he might not have seen any necessity for it. Although Freud frequently refers to the insecure economic situation of his family, to the *Not des Lebens* (demands and toils of life) to which he was early exposed, Jacob Freud had in fact somehow managed to keep the family reasonably well fed and clad, and living in a spacious apartment. None of the children had to interrupt his education, and even some of the luxuries were provided. There was money for books, for theatre tickets, for a piano, for music lessons, for an oil painting of Sigmund at the age of nine, and of all of the children several years later, for a modern and improved petroleum lamp—the first of its kind in Vienna—and even for summer vacations at a resort in Moravia.

Freud's dependence on his family, though fairly complete, was not painful. At the age of twenty-six he still lived in his own tiny, private study that had been allowed him as a privilege in his early teens. 'All through these years . . . the only thing that changed in this room was the increasing number of crowded book cases which, added to the writing desk, bed, chair and shelf, furnished it' (Bernays (1), p. 336). His person and his studies were taken very seriously by his family. Freud required and received a good deal of privacy. Periodically he took his dinner in his own room and not at the family table, but otherwise he was extremely unassuming. He was not demanding in material things, being content with the simplest of clothing, food and entertainment. It seems that apart from peace and quiet for reading, and the company of stimulating friends, he wanted little else than books: and these were available, most of the time, for a very small amount of spending money. His passion for books—expensive illustrated scientific monographs—had brought him trouble once in the beginning of his university years, but was fairly well under control after that. Embarrassing situations occurred periodically, when he had to borrow money from friends, whom he then repaid conscientiously, even sooner than was expected. We know of one such episode from the only letter saved from the correspondence with his friend Knöpfmacher. Occasionally

[6] Letter by Freud to Wittels; communication from Dr. Wittels.

he earned an honorarium for his publications, and in 1879 he received a University grant of 100 gulden. Life with his family was, of course, not free from friction. Strongly suppressed criticism of his father must have created tensions and anxieties in the son, particularly before his trip to England, where his half-brother, twenty-three years his elder, taught him to see his father in a new light. But in spite of his withdrawal into his study, he lived not just in his family but with it. He participated in the joys and worries of its members and took an active interest in the affairs of them all. He was asked for counsel, and his opinion was frequently followed. Being one of a large and close family group was his natural living atmosphere from his earliest childhood years on. There was hardly a chance for him to feel ' parasitic '. That a part of the emotional turmoil and instability which he, like any adolescent, must have suffered, was in fact the outgrowth of his dependence, he knew as little as his contemporaries did at that time. Maybe he knew it even a little less than did those of his friends who in rebellion against their fathers spent their stormy lives as socialists, almost as outcasts, or led queer existences in coffee houses and vegetarian restaurants or wasted their academic freedom in drinking, duelling and singing. Any conscious embarrassments and frustrations of his situation were well compensated for by the happy work-life in the steadying and gratifying atmosphere of the Physiological Institute, where only one thing counted: science, and devotion to its progress. He wanted this happy state to continue for ever. In fact, it contained so many and such strong factors of stability that only an elementary, external force could threaten the equilibrium. His father might have died or an economic depression might have wiped out his business. But for Freud it was neither death nor destruction, but Eros, that became the disturber.

In the spring of 1882 Freud met Martha Bernays of Hamburg, who was in Vienna for a short visit. She was then not quite twenty-one years old. After only a few weeks of intense, shy, secret courting, he proposed to her in a letter and received as her consent, ' a hasty and tender handshake under the table ' (13, *G.W.*, 2/3, p. 662). On June 17, 1882 they celebrated their formal engagement. Freud, impatient, wished to marry soon. This fact he has omitted from his several presentations of ' the turning point '. Such an omission by no means indicates that he judged it to be irrelevant. Freud, in all his confessions—so generously dispersed throughout many of his writings—has censored with great consequence any reference to love. He has presented himself as a villain, as patricidal, ambitious, petty, revengeful, but never as a lover, save for a few lines of the most restrained allusions to his fiancée and wife. Even the report of his adolescent infatuation he has given away only in the disguise of a case history.[7] This is a warning to the biographers of Freud not to assume that his autobiographical statements are random samples. Quite to the contrary, they are rigidly censored, and follow criteria that are not obvious.

With this information added, the motivation of Freud's decision to leave the Physiological Institute becomes understandable, very human and quite realistic. His fiancée was poor, and Freud was proud of it, but a professorship was very far in the future. One had to work several years in order to get as a preliminary condition the title of Privat-dozent, and then without an accumulation of fortunate and rare circumstances came many more years before promotion to professor, and this, in any case, was never assured. It was true that he was in line for the next opening as an assistant in Brücke's Institute, and this position brought a small salary with it. A family could not live on it; yet without children and with outside help a young couple might be able to struggle along. The Physiological Institute had two such assistant positions, but both were in the hands of able and relatively young men. There was no hope of their departure or promotion. Basic research did not offer any likely chance for economic independence and stability, in either the near or the distant future. For a Jewish student the prospect was even darker; one who refused to consider baptism as the entrance ticket into the academic world could be certain only of repeated slights and excessive delay. Since for Freud ' the days were over when all that one needed in life was food for the mind ' he felt that he had to leave the university and the dream of becoming like Brücke a professor Ordinarius in ' higher anatomy and physiology '.

---

[7] See Bernfeld (2). The object of Freud's infatuation had been the sister of Richard Fluss, who was present at the graduation ceremonies, see above, p. 206.

III. In the General Hospital

Freud had acquired his medical degree the year before 'the turning point'; all he had to do was to hang his diploma in any room of his living quarters, thereby designating it his consultation room; to put up a plate at the front door and to wait for patients. His desires and his impatience might have tempted him to do exactly that when he left Brücke's Institute—and science. Hundreds of doctors had done so; had earned a living, and some of them even the gratitude and love of their patients. Yet such doctors remained at the bottom of the professional hierarchy as it existed in Austria at that time. The average respectable physician derived his higher standing—that above country-doctor level—from several years of voluntary residence in the General Hospital in Vienna. This earned him the coveted title 'Emer. Secundararzt', former assistant physician, under his name on his nameplate and in the directory. Enthroned above this broad middle class of respectable physicians was the medical aristocracy—the university men with their own hierarchy of Privat-dozent, a.o. professor, and professor. Their career usually began with the position of assistant in one of the University Clinics, which, although located in the General Hospital building, were under the administration of the University and enjoyed considerably more prestige. Freud took his place in the middle group. In July, 1882, he entered the General Hospital as a candidate (aspirant) for the position of assistant physician, which is roughly the equivalent of our resident.

One might speculate about Freud's motivations. Did he hope, through this delay of several years, to support his family better in the long run? Was respectability for him, or for his fiancée, a goal worth the delay? Was it just the proper thing to do, so much so that it appeared to be inevitable? Or did he, unknown to himself, desire a well-rationalized delay? There are no known facts to encourage any such complex interpretation. Yet there existed one very simple and trivial fact in Freud's mind: whether or not he liked medicine he certainly did not know those medical skills to which he was certified. His training had consisted only in lectures and in case presentations in the amphitheatre. He had hardly ever seen a patient in his bed, and those few times he had been permitted to examine but not to treat him. He was a doctor by law only, not by conscience. His place was not yet on his own in a private consulting-room but in the General Hospital under the supervision of a chief.

Three thousand or more patients lived in the wards of the old grey musty buildings of the General Hospital that covered twenty-five acres near the centre of Vienna. They had come not only from the capital, but from all the wide provinces of the Austrian monarchy and from Asia and Africa as well. Several thousands more consulted the out-patient departments. The rarest cases that elsewhere could be seen but once in a life-time were there exhibited regularly. Although the rococo sign of 1780 over the main entrance promised 'cure and consolation for the sick', the spirit of the men that had made the place famous was devoted to investigation and observation rather than to therapy. Hyrtl, Skoda, Rokitansky—to mention only three of the most influential—had found their life task in the overthrow of that mixture of bigotry and age-old wisdom, magic and common sense, showmanship and genuine kindness that had—with notable exceptions—passed for medical practice in the first half of the nineteenth century. They had successfully replaced these methods by examination, observation, the microscope and the autopsy. These men had broadened medical knowledge considerably, they had built up the foundation for empiric and effective treatment, but therapy had remained a mere promise of the future. These founders were dead or retired by 1882. They were replaced by men of the same spirit which has, with some exaggeration, been called therapeutic nihilism. They continued the tradition of the school: 'Who diagnoses well cures well'; you do a patient a greater harm by treating him for a disease he has not got than by nursing him well and leaving the rest to nature. The gynæcologist Chrobak, for example, kept a large sign in his auditorium which read: *Primum est non nocere* (The supreme commandment is: Do no harm)' (Wittels (19), p. 522).

Out of his own experience Wittels describes the spirit of the Vienna School: 'Whenever a patient died the doctors went—I was about to say they ran—to the Institute for Pathological Anatomy. The chief, his assistants and the younger doctors in their white smocks assembled. The day of judgement had come. . . . The post-mortem finished, we walked back to the wards, sometimes slightly discouraged, and congregated in the chief's sanctum for the

epicrisis which meant a thorough critical discussion of the case.'

Yet the patients, then as now, looked to the doctors, and especially to the professors, as powerful helpers, indeed as demigods. For them consultation with a famous physician meant assurance of a cure. In this uncomfortable position of a hapless and powerless ignoramus garbed with omniscient authority the physician tried to compensate for his therapeutic nihilism by idealistic and altruistic devotion to the patient.

One of the pure representatives of the type was Nothnagel. His conception of medical duties was extremely strict. He said to his students: ' Whoever needs more than five hours of sleep should not study medicine. The medical student must attend lectures from eight in the morning until six in the evening. Then he must go home and read until late at night.' He himself might not have had even that much sleep. In addition to scientific and editorial work, to teaching and the administrative duties of his large department, he brought solace, if not cure, to a large clientèle of wealthy Viennese and foreigners, and he travelled to remote villages in order to minister to the poor and obscure. It was hard for him to refuse a case. He was loved, admired and idealized. He died prematurely at the age of sixty-four, of a heart attack. Notes on pulsation and feelings that the dying man had jotted down in the moments of his last steno-cardiac attack were found on his bedside table together with a volume of Schiller's works, opened at the philosophical poem ' The Ideal and Life '. His death, quite symbolic for the type of the ' good physician who must be a good man ' as he had said in his Inaugural Address in Vienna in 1878, had made him for a long time a legend in the minds of the sick in Vienna as well as abroad.

It was in Nothnagel's Division of Internal Medicine in the General Hospital that Freud worked as candidate (aspirant) from July to December of 1882. But, it seems, he found no more interest in treating the sick in the wards than he did in watching the professor make a diagnosis or perform operations in the amphitheatre. Freud was impressed by the scientist Nothnagel, he greatly respected the man, but he was unable or not tempted to appreciate and emulate Nothnagel's medical temperament. In his wards Freud soon and finally became convinced that he could not or did not want to face a future as general practitioner or as an internist—as a doctor, in short. After the term with Nothnagel had expired he did not enter another of the divisions of the hospital for the next four months.

Not in the hospital, but in Meynert's Laboratory for Cerebral Anatomy, did he find the work that fascinated him. Meynert, who is recognized as one of the founders of cerebral anatomy, was at that time looked up to with awe and admiration as unquestionably the greatest man in his field. Already as a student Freud had been fascinated by the work and the personality of this man. In spite of bitter personal disappointments in later years, Freud always recalled him as the most brilliant genius he had ever met. This laboratory ' of the great Meynert in whose footsteps I had followed with such veneration ' (12, p. 417), Freud entered in the autumn of 1882, simultaneously with his service in Nothnagel's Division, and he remained there until his departure for Paris in the autumn of 1885. He shared his laboratory table with Bernard Sachs and Allen Starr from New York and Anton of Vienna. Soon he was as devotedly at work there as he had ever been in Brücke's Institute. And, regardless of his plans to prepare himself for private practice, in spite of his longing for his fiancée and quite against reason, he found his passion for research indomitable. In a certain sense he remained faithful to the same topic which he had given up only a few months before. ' The subject which Brücke had proposed for my investigations had been the spinal cord of the primitive fishes, and I now passed on to the human central nervous system ' (15, p. 17). But in its practical value ' brain anatomy was certainly no advance beyond physiology.' Fortunately this time a compromise between ideal and reality presented itself in the field of the diseases of the nervous system—neuro-pathology, as it was then called. This medical speciality demands a thorough knowledge of brain- and nerve-anatomy, and in fact was at that time, even more than it is to-day, merely a diagnostic application of anatomy. ' I knew just enough medicine to become a neuropathologist,' Freud wrote ten years later, sarcastically, to his friend Fliess (17, p. 66). Thus he evolved the plan to study neuro-pathology at the General Hospital, to earn through a number of publications the academic standing of a University lecturer (Privat-dozent), to round out his education with a term in Paris under the guidance of Charcot, and then to

establish himself in private practice as a specialist in neurology. This plan promised a fairly secure future. The pursuit of brain anatomy was no longer an irrational hobby but an integral part of his preparation for a reasonable goal.

It is not known when, exactly, Freud reached his decision. We know that he resumed on May 1, 1883, his service in the General Hospital. There he was appointed Assistant Physician in Meynert's Division of Psychiatry. With this position went a free room, firewood and a token salary, the same amount that the gas-lamp-lighter received. Thus at the age of twenty-seven Freud, for the first time, moved out of his parental home and lived on his own. But he spent most of the week-ends with his family and his books.

For five months Freud served in Meynert's Division of Psychiatry; after that for a brief period in one of the syphilis wards, and then from December of 1883 until the summer of 1885 in the Fourth Medical Division, where for many years its chief, Dr. Franz Scholz, had shown great interest in neurological cases. Although his wards remained open to cases of every kind, it was in his division that one could always find a great number and variety of 'nerve cases'. This curriculum—going from the psychiatric division to the syphilis ward and from there to Scholz' division—seems to indicate that the plan to specialize in neuro-pathology was devised early in 1883.

Was the decision reached after an intense struggle? Was he disappointed with himself, ashamed and depressed, or had he, at twenty-seven, that unperturbed, impartial acceptance of his own limitations which, as an old man, he expressed in the simple sentence: 'I lacked the proper medical temperament'? To his own failures Freud reacted very strongly, as is shown by a remarkable insertion in his *Interpretation of Dreams* which refers to his chemical efforts in Ludwig's laboratory in 1881–1882. 'As a young doctor, I worked for a long time in the Chemical Institute without being able to accomplish anything in that exacting science, so that in the waking state I never think about this unfruitful and actually somewhat humiliating period of my student days. On the other hand, I have a recurring dream to the effect that I am working in the laboratory, making analyses, and experiments, and so forth; these dreams are disagreeable, and they are never very distinct. During the analysis of one of these dreams my attention was directed to the word 'analysis', which gave me the key to an understanding of them. Since then I have become an 'analyst'. I make analyses which are greatly praised—psycho-analyses, of course. Now I understand: when I feel proud of these analyses in my waking life, and feel inclined to boast of my achievements, my dreams hold up to me at night those other, unsuccessful analyses, of which I have no reason to be proud; they are the punitive dreams of the upstart . . .' (12, pp. 445–6).

What warns us to assume that he felt equally strongly about his inability to learn medicine is the great difference in the respective importance of these two fields. Chemistry was the subject to which Freud felt attracted and in which he wished to be proficient, while medicine was forced upon him, through his father's fault, one may say. Had his father been rich and powerful, as he appeared to the child in his home town, no need would have existed to consider a practical way for the satisfaction of the young student's thirst for knowledge; no 'miserable financial' situation would have compelled the young doctor to pay, with his scientific career, for his urge to be independent and a *paterfamilias*. The practice of medicine to him was a tribute to the *Not des Lebens*, to the reality principle as he was to call it later; and he probably felt fully justified in paying as little as possible for his father's deficiency, namely, by choosing that corner of medicine which was closest to his scientific interest and farthest from the regular business of the physician. It does not seem that he ever regretted this choice, although in a passing mood he wrote to a friend five years later: 'To be a physician and not merely a specialist; to use all available means of examination; to take over completely; that is certainly the only method which promises both personal gratification and financial success, but that is no longer for me' (17, p. 66).

IV. Anatomy of the Medulla Oblongata

As part of his vocational plan, in the autumn of 1883 Freud started on a research programme in cerebral anatomy. In the preceding years he had acquired a general knowledge of the brain as Meynert saw it, and already during his student years he had been well acquainted with the nerve cells and the spinal cord through his work with Brücke. The medulla oblongata, as the transition of the spinal cord into the cerebrum, thus seemed a logical starting point

for his investigations. The structure of this important portion of the brain was at that time little known and a highly controversial subject. The nerve tracts originating in or passing through the oblongata are especially difficult to discern, to separate and to trace. The connexion of the cranial nerves with the oblongata—which is obviously the place of their origin—was not yet known, at any rate not satisfactorily and in detail. Some of Meynert's old findings seemed shaken by newer publications. This challenging field Freud wished to explore, and he resolved to concentrate on it for some time to come.

One of the handicaps of such research was the failure of the techniques then in use for dyeing or otherwise marking off the nerve tracts to produce clear pictures in the macroscopic preparation. Following a hint of Flechsig's, Freud developed, in the autumn of 1883, the gold chloride method, which—although by no means a decisive improvement—was of some help. I have discussed—in a previous paper—the publications in which he described this invention (3, p. 22).

Freud devoted a good portion of his time from 1883 to 1885 to the study of the oblongata. In three papers he published (1885–1886) only a small part of his findings and of the theoretical concepts to which they led him. He mentioned this work in his Autobiography as ' Short Papers, which were regularly noted down by Edinger '. Two of them are, in fact, just little papers clarifying definitely or preparing the future determination of several structural details of the oblongata: (1) ' On the Interolivary Tract ' and (2) ' On the Connection of the Inferior Peduncle with the Posterior Columns of the Cord '. The manuscript of the former is dated ' Vienna in the middle of May 1885 '. It appeared in June, 1885 (7); the manuscript of the second, dated ' Paris, January 23, 1886 ', appeared in June, 1886 (9). The latter is co-signed by Dr. L. Darkschewitsch, a young Russian neurologist who worked from 1883 to 1887 with Flechsig, Virchow, Goltz, Meynert and Charcot. On his return to Russia he became Privat-dozent in Moscow; in 1882, Prof-Ordinarius in Kazan. He is credited, in the obituaries at least, with having been the ' Russian Oppenheim ', the founder of the Neurological School of Kazan, which was in its time the largest and the most famous in Russia. Freud met Darkschewitsch in Meynert's laboratory or in Paris, and as he says: ' Independently of each other, we both had found confirmation for the Flechsig-Meynert hypothesis. When we noticed the complete agreement in our findings, we decided to report on them in a joint publication ' (9, p. 123).

The third paper on the medulla oblongata ' On the Origin of the Acoustic Nerve ' (10)—written in July and published in August, 1886, upon Freud's return to Vienna from Paris—surpasses the level of the investigation of a detail that fills in one blank spot or two on the map of the brain. Here Freud not only traces the nervus acusticus (VIII) to its root in the medulla, but by comparing this result with his early findings in his petromyzon studies he formulates the theory that the roots of all the posterior cranial nerves are homologous to the roots of the spinal posterior nerves, and thus he brings simple order into a chaotic and confused field. For the acusticus he proves this homology convincingly. The generalization over all the cranial nerves was subsequently generally accepted, according to Brun (4, p. 202).

All Freud's investigations into the medulla have one very significant feature in common; the method that he adopted. The standard technique at that time was to slice the brain into a large series of slides and to study in these series the course and the connexions of the nerve tracts, either purely anatomically or in combination with physiological facts. In these latter efforts the knowledge of the results of spontaneous or artificial lesions was used—of ' mutilations ' as Freud puts it so characteristically for his attitude to physiology. He felt strongly sceptical about the current enthusiastic belief in these methods and saw a far better tool in the newer method that Flechsig had recently introduced. Here an embryological fact becomes the guide in the maze of anatomical connexions. The maturation recognizable by the myelinization of the nerve tracts does not occur simultaneously over the whole nervous system, but in precise steps that succeed each other in a regular way. Therefore if instead of the fully matured object the brain is studied in its fœtal phase, one sees simple pictures in which only a few tracts appear instead of the ' inextricable pictures of cross sections, which permit hardly more than a superficial topographical survey ' (10, p. 247). By comparing the sections through a fœtal brain at different levels, one can directly observe the course, the connexions and the composition of the nerve tracts, which can only be guessed at from their mature appearance. The basic assumption of this

method is obviously, as Freud clearly states, that the earliest structures persist during the development, that they become only more and more complicated, but are ' never buried '; ' nicht verschüttet ', are the exact words Freud uses here in 1886 (10, p. 247).

Already in his histological research the problem of development had been of paramount interest, but then it was the phylogenetic angle of evolution that he had pursued. In his oblongata studies this same problem of evolution remains the goal, but he approaches it now with the ontogenetic aspect in focus.

No long discussion is needed in order to prove that one of the themes of psycho-analysis originates in this oblongata research. In the emotions of man, Freud later found another field in which the ontogenetic point of view—based on the assumption behind the Flechsig method—led to fruitful results. Only here Freud had first to find a way of digging out the archaic structures, which—though not destroyed—are in fact deeply buried, ' verschüttet '.

We can easily imagine that Meynert was impressed by Freud's intensity, originality and devotion. ' One day Meynert ' says Freud, ' who had given me access to the laboratory even during the times when I was not actually working under him, proposed that I should definitely devote myself to the anatomy of the brain and promised to hand over his lecturing work to me as he felt he was too old to manage the newer methods. This I declined in alarm at the magnitude of the task; it is possible, too, that I had guessed already that this great man was by no means kindly disposed towards me ' (15, p. 18). The oblongata studies were fully within the framework of Meynert's teaching. They promised to add to his fame—a point that counted heavily with Meynert. Yet in these papers Freud was to some degree a propagandist for Flechsig. The ageing Meynert, increasingly distracted from brain anatomy by his psychiatric interests, felt threatened by ' these newer methods ' with which he was not familiar. It is quite in keeping with his highly complex personality that, under the pressure of such conflicting feelings, he came out with a gesture of submission, offering to retire altogether from teaching brain anatomy and challenging Freud to take over. Freud would have heard the overtones of jealousy and hostility in that offer so much the louder since his interest in Flechsig's work—beyond its scientific justification—meant in fact, emotionally, a breach of loyalty to Meynert, of which—as an expression of his own complex relation to the master—he must have felt very guilty.

V. Clinical Neurology

In spite of Freud's earnest involvement with brain anatomy he did not forget the study of organic nervous disorders. It was a challenging task. In the General Hospital no special division of neurology existed, and the cases were dispersed throughout the divisions for internal medicine. No major courses specializing in these disorders were given at the University. Nothnagel, who shortly before had been called to Vienna on the merits of his book on brain localization, did not emphasize neuropathology either in his clinic or in his classes. Meynert's psychiatric classes, though highly stimulating, focused on general brain anatomy and on specific psychiatric topics such as amentia. What Obersteiner and a few Privat-dozents—Benedickt and others—had to offer, Freud had soon consumed. Scholz, his chief in the hospital division, had done scientific work in internal medicine more than twenty years before and had always preferred neurological cases, but in 1883 at the age of sixty-four he was a ' fossil and notoriously feeble-minded ' (Freud (13), *G.W.* 2/3, p. 678), a laughing-stock for his students. But at least, perhaps owing to his senile indolence, his assistants were free to do exactly as they liked. Thus Freud had to be his own teacher and was apparently successful at it. ' I gradually became familiar with the ground; I was able to localize the site of a lesion in the medulla oblongata so accurately that the pathological anatomist had no further information to add . . . the fame of my diagnoses and of their post-mortem confirmation brought me an influx of American physicians to whom I lectured upon the patients in my department in a sort of pidgin-english ' (15, p. 19). Scholz appreciated his assistant physician very much; he soon gave him the functions, though not the title or the salary, of a senior assistant-physician, and for six weeks entrusted him with the responsibilities of acting chief of the division.[8]

Only three cases of the many that Freud

[8] There were fifty to a hundred patients, half of them male; two assistant physicians and one senior assistant physician. The assistant physicians participated by turns in the twenty-four-hour admission service of the General Hospital.

observed and treated in the Fourth Division are on record. All occurred in 1884, and Freud published them in three papers during the years 1884–1886. Although in the first instance the motive for these publications was probably the consideration of his academic standing, these cases are written up with obvious gusto; ' models of good neurological deduction ' (18, p. 702). In his later years Freud frequently spoke with contempt of the neurology of the 'eighties. Once, significantly, he scolded it as being a silly game of permutations. Yet in his first years as a neuropathologist he played this game with skill and fascination.

One is the case of a sixteen-year-old cobbler apprentice who entered the hospital on January 17, 1884, with freely bleeding gums and smaller hæmorrhagic areas in the lower limbs, but showing, except for a certain apathy, no other symptoms than scurvy. In the morning of the next day he was in a deep coma and died in the evening. During the day, closely observed at frequent intervals and examined neurologically as thoroughly as possible, he showed very confusing behaviour—vomiting, eye palsies, papillary irregularities, hemiparesis, etc. A thorough discussion of each of these observable symptoms in terms of clues for the kind and the place of hidden pathological occurrences in the brain led to a precise diagnosis of scurvy, combined with ' hæmorraghia cerebræ intermeningealis et ad crura cerebris et retinarum '. The autopsy conducted by Kunradt confirmed the deduction in each detail. In the publication of this ' Case of Cerebral Hæmorrhage in Scurvy with Basal Symptoms ' Freud thoroughly discussed the literature and some particulars of basal hæmorrhagias (5).

Then there is the case of a young baker whom Freud observed from October 3, 1884, until his death on December 17 of the same year and diagnosed as a case of endocarditis, pneumonia and acute multiple neuritis (poliomyelitis acuta)—confirmed by the autopsy (Kunradt) and published as a first case of this disease ever studied in Vienna (8, p. 39). Freud promised in this paper to report on the results of the microscopic examination in more detail. It seems that he did not publish the planned continuation. However, Sperling wrote in the *Neurologisches Centralblatt*, 1886: ' This is a very valuable contribution to the clinic of acute multiple neuritis heretofore lacking in detailed microscopic examination ' (18, p. 702).

This same game—if it is so to be called—of observation, analysis and intuition based on the knowledge of anatomy and of the clinical literature, led Freud in the third case to the diagnosis of muscle atrophy with extensive sensibility disassociation (syringomylie) of which, at that time, very few cases were known (6). The patient, a weaver, thirty-six years old, was for six weeks—from November 10, 1884, onwards—not only under Freud's observation, but under Faradic treatment, and seems to have left the hospital ' claiming some improvement '.

VI. Privat-dozent

Already in January, 1885, hardly more than a year and a half after Freud had decided on his definite vocational plan, he felt close to his goal. On January 21, undoubtedly encouraged by Brücke or Meynert, he filed his application for the appointment as ' privat-dozent ' [9]

No exact equivalent to this position exists in American universities. The Privat-dozent was not admitted to faculty meetings and he drew no salary. He was permitted to give a limited number of classes, usually one or two, each of one to two hours weekly. He covered topics that did not belong to the required curriculum of the medical student and he was obliged to ask for the standard enrolment fee. His classes therefore were, in general, very small. Ten students were considered an unusually large number except in the case of a few spectacularly popular teachers. The requirements for the appointment were very high. Proof was demanded of independent, original and valuable scientific achievement by means of a great number of publications. Yet this lectureship was a highly prized goal. It was a necessary condition for a future appointment to a professorship and enjoyed high prestige with the public. Since no specialty boards existed, the title of Privat-dozent certified to the public an above-average competence in the limited field. Moreover it gave this authority to an exceedingly small group. And though in fact not infrequently men with good connexions in higher places had achieved the coveted position without merits, in general the privat-dozents held a high scientific level and

[9] Thanks to the efforts of Professor Viktor Kraft in Vienna I have been able to use the documents preserved in the archives of the Vienna University.

had contributed more than their share to the progress of science.

Freud's application, signed January 21, 1885, contained a curriculum vitæ, the bibliography of his published works and his proposed programme of teaching, 'Lehrplan'. 'If the Honourable College of Professors will grant me the lectureship (*dozentur*) on Diseases of the Nerves, then it is my intention to promote in two ways the instruction in this branch of human pathology; first, through lectures and classes on the anatomy and physiology of the nervous system, as far as knowledge of this kind is the necessary preparation for the understanding of the neuro-pathological facts; second, through classes and lectures, in which nerve patients will be presented, the necessary methods of examination will be shown and the present knowledge concerning the pathology of the nervous system will be taught. For this latter purpose Herr Primarius Dr. F. Scholz has very kindly put at my disposal the material of the Fourth Medical Division in the General Hospital in which I am serving as an assistant physician.' Dr. Scholz confirmed this promise with his signature.

In the faculty meeting of January 24 a committee was elected, consisting of Meynert, Brücke and Nothnagel, with the purpose of discussing the application, and of reporting their findings to the faculty. On February 1 Brücke communicated his opinion briefly to this committee: 'The microscopic anatomical papers by Dr. Freud were accepted with general recognition of his results. In so far as they have been checked up to now they were confirmed. I know his work very well and I am ready to sign any report that recommends the acceptance of the applicant. I am willing to appear at a committee meeting, if such a meeting should become necessary.' On February 5 Nothnagel agreed with Brücke's opinion and on February 28 Brücke presented to the faculty meeting the report of the Committee, written by himself and signed by Meynert and Nothnagel.

In his report Brücke analyses carefully and extensively Freud's three histological papers on The Posterior Roots in Petromyzon (1877, 1878) [10] and the Nerve Cells in Crayfish (1882),[10] calling the latter work 'very important'. He gives shorter, appreciative abstracts of "A New Method of the Anatomical Preparation of the Central Nervous System" (1879),[10] 'A Histological Method for the Study of Brain Tracts' (1884) [10]; of 'A Case of Cerebral Hæmorrhage' (1884) [11] and of 'On Coca' (1884).[12] He mentions the zoological paper on the eels (1877) [10] and Freud's summary of his neuro-histological studies 'Structure of the Elements of the Nervous System' (1884).[10] He closes with the following recommendation: 'Dr. Freud is a man with a good general education, of quiet and serious character, an excellent worker in the field of neuro-anatomy, of fine dexterity, clear vision, comprehensive knowledge of the literature and a cautious method of deduction, with the gift for well organized written expression. His findings enjoy recognition and confirmation; his style of lecturing is transparent and secure. In him the qualities of a scientific researcher and of a well-qualified teacher are so well united that the committee submits the suggestion that the honourable college resolve on his admission to the further habilitation tests.' The faculty meeting accepted this recommendation immediately by twenty-one to one. On June 13 Freud passed the oral examination with Brücke and Meynert. On the 20th, the faculty decided to permit Freud to present his 'trial lecture'. This time his only opponent from a previous meeting—so it seems—found helpers, the decision being nineteen to three. The trial lecture was given on June 27 at 12.30 p.m. in Brücke's auditorium. Freud had chosen as his topic 'The Medullary Tracts of the Brain'.[13] The official report states that this lecture in the presence of 'Brücke, Meynert, Fleischl, privat-dozents, assistants, doctors and many students, was accepted with unanimous satisfaction'. Therefore the faculty, on July 18, appointed Freud as privat-dozent in neuro-pathology; this appointment was confirmed by the Ministry for Public Instruction on September 5, 1885.

Freud thus belonged to the aristocracy of the medical profession, although to its lowest échelon. At the same time he was awarded a travelling grant for a half-year's study at Charcot's Salpêtrière in Paris. His student years—nine at the University and three in the General Hospital—were definitely over. Although he counted the time in Paris as a part of

[10] Information on these papers in Bernfeld (3).

[11] See above, p. 214.

[12] This and the later papers by Freud on Cocaine will be the topic of a separate study, although they belong chronologically to Freud's General Hospital period.

[13] Medullary tract is Bernard Sachs' translation of Meynert's term: *Markfaser*. The meaning is: tracts within the white cerebral substance'.

his learning, and though he had planned it for reasons of prestige as well as for further increasing his security and competence in his profession, the trip to Paris that he started late in August or at the beginning of September, 1885, fulfilled in fact an intense longing of many years' standing. ' The felicity which I felt when I first set foot on the pavement of Paris, was to me the warrant that I should attain to the fulfilment of other wishes also.' (12, p. 259.)

I. Notes

Note to I

Additional information on the zoologist Claus and the pathologist Stricker, their institutes and Freud's relation to them in Bernfeld (3).

Note to II

The facts on which the presentation and conclusions are based are autobiographical remarks scattered throughout Freud's writings and from Bernays (1)—the date of the engagement: personal communication from Miss Anna Freud, London; information on Freud's letter to W. Knöpfmacher: personal communication from Mr. Hugo Knöpfmacher, New York.

Note to III

The presentation is based on Freud's scattered autobiographical remarks—the ' curriculum vitæ ' written by Freud, January 21, 1885 (from the Archives of the Vienna University)—personal communication from Dr. Fritz Wittels, New York —contemporary medical journals, especially *Presse Medicale Belge*, **44,** 1883; Dr. Joseph Hofmann, *Das Wiener K.K. Allg. Krankenhaus*, Wien, 1873; *Das Wiener Allg. Krankenhaus, 1784–1884*, herausg. Min. f. Soc. Verw. Wien, 1934; H. Hun, *Guide to American Medical Students in Europe*, New York, 1883; Eisenberg, *Das geistige*, Wien, 1895; Wittels (19).

Note to IV

Freud's relation to Meynert will be discussed in a separate paper, where the sources of information will be given—Freud's expression ' Meynert, the most brilliant genius ', personal communication from Dr. Heinz Hartmann, New York.

Note to V

The information on Schulz' Division from the sources used in III—Freud's expression ' Neurology, game of permutations ': personal communication from Mrs. Suzanne Bernfeld, San Francisco.

II. Appendix: Complete list of the classes in which Freud registered and paid for:

Winter Semester, 1873–74		*hours per week*
Langer	Anatomy	6
Langer	Dissection	6
Schneider	Chemistry (Lab.)	6

Summer Semester, 1874		*hours per week*
Langer	Anatomy	6
Claus	General Biology and Darwinism	3
Schneider	Organic Chemistry	5
Schneider	Chemistry (Lab.)	6
Toldt	Microscopy (Lab.)	3
Fenzel	Botany (System of the Phanerogamia)	3
Czermak	Mineralogy	5
Brücke	Physiology of Voice and Speech	1

Winter Semester, 1874–75		
Voigt	Dissection	6
Brücke	Physiology	5
Brücke	Physiology (Lab).	6
Claus	Zoology for Medical Students	5
Stephan	Magnetism, Electricity, Heat	4
Stephan	Theory of Magnetic Forces	2
Brentano	Reading of Philosophical Works	1

Summer Semester, 1875		
Brücke	Physiology	5
Brücke	Physiology (Lab).	6
Claus	Anatomy of the Vertebrata	5
Claus	Anatomy of the Mollusca	2
Claus	Zoology for Beginners (Lab.)	3
Brentano	Logic	1
Brentano	Reading Seminar	1
Stephan	Optics	3
Stephan	Theory of Heat Conduction	2

Winter Semester, 1875–76		
Langer	Anatomy (Lab.)	6
Brücke	Physiology (Lab.)	6
Claus	Zoology (Lab.)	10
Fleischl	Physiology (Discussions)	2
Brentano	Reading of Philosophical Works	1

Summer Semester, 1876		
Claus	Zoology (Lab.)	15
Fleischl	Physiology (Muscles and Nerves)	4
Exner	Demonstration in Medicine and Physiology	2
Exner	Spectrum Analysis	2
Wiesner	Plant Physiology	3
Brentano	Philosophy of Aristotle	3

Winter Semester, 1876–77		
Dumreicher	Clinical Surgery	10
Duchek	Clinical Medicine	10
Stricker	General Pathology	5
Heschl	Pathological Anatomy	5
Exner	Physiology of the Sense Organs	3
Fleischl	Physiology (Discussions)	2
Fleischl	Higher Mathematics for Medical Students	3
Basch	Action of Poisons	2

Summer Semester, 1877		
Billroth	Clinical Surgery	10
Bamberger	Internal Medicine	10

		hours per week
Heschl	Pathological Anatomy	5
Hoffmann	Medical Jurisprudence	3
Fleischl	Physiology (Muscular and Nervous Systems)	3
Winter Semester, 1877–78		
Billroth	Clinical Surgery	10
Duchek	Clinical Medicine	10
Meynert	Clinical Psychiatry	5
Heschl	Pathology (Lab.)	3
Langer	Dissection	6
Ludwig	Physiological and Pathological Chemistry	3
Breuer	Diseases of the Kidneys	2
Summer Semester, 1878		
Billroth	Clinical Surgery	10
Hebra	Clinical Dermatology	10
Späth	Clinical Obstetrics	10
Sigmund	Clinic of Syphilis	5
Stricker	General Pathology of the Nervous System	1
Bettelheim	Physical Examination	5
Winter Semester, 1878–9		
Bamberger	Internal Medicine	10
Arlt	Ophthalmology	10

(Received December 10, 1950.)

BIBLIOGRAPHICAL REFERENCES

(1) BERNAYS, ANNA. 'My Brother Sigmund Freud', *Amer. Mercury*, **51,** 203, November, 1940.

(2) BERNFELD, SIEGFRIED. 'An Unknown Autobiographical Fragment by Freud', *Amer. Imago*, **4,** 1946, 3–19. Reprinted in *Yearbook of Psychoanalysis*, **3,** 1947, 15–29.

(3) —— 'Freud's Scientific Beginnings', *Amer. Imago*, **6,** 1949, 3–36. Reprinted in *Yearbook of Psychoanalysis*, **6,** 1950, 24–50.

(4) BRUN, R. 'Sigmund Freuds Leistungen auf dem Gebiete der organischen Neurologie', *Schweizer Ar. f. Neurol. u. Psychiatr.*, **36,** 1935, 200–208.

(5) FREUD, SIGM. 'Ein Fall von Hirnblutung mit indirekten basalen Herdsymptomen bei Skorbut', *Wiener Medizinische Wochenschrift*, **34.** Jahrgang, 9, März 1, 1884, 244–246; 10, März 8, 1884, 276–279.

(6) —— 'Ein Fall von Muskelatrophie mit ausgebreiten Sensibilitätsstörungen (Syringomyelie)', *ibid.*, **35.** Jahrgang, 13, März 28, 1885, 389–392; 14, April 4, 1885, 425–429.

(7) —— 'Zur Kenntnis der Olivenzwischenschicht', *Neurologisches Centralblatt*, **4.** Jahrgang, 12, Juni 15, 1885, 268–270.

(8) —— 'Akute multiple Neuritis der spinalen und Hirnnerven', *Wiener Medizinische Wochenschrift*, **36.** Jahrgang, 6, Februar, 1886, 168–172.

(9) —— und DARKSCHEWITSCH, L. 'Über die Beziehung des Strickkörpers zum Hinterstrang und Hinterstrangskern nebst Bemerkungen über zwei Felder der Oblongata', *Neurologisches Centralblatt*, **5.** Jahrgang, 6, März 15, 1886, 121–129.

(10) —— 'Über den Ursprung des N. Acusticus', *Monatsschrift für Ohrenheilkunde sowie für Kehlkopf-, Nasen-, Rachen-Krankheiten*, Berlin, **20.** Jahrgang, 8, August, 1886, 245–251; 9, September, 1886, 277–282.

(11) —— (1899). 'Screen Memories.' Transl. James Strachey. In: *Collected Papers*, **5,** 47–69.

(12) —— (1900). 'The Interpretation of Dreams,' in: *The Basic Writings of Sigmund Freud*, transl. and edited by Dr. A. A. Brill. (New York: The Modern Library.) Pp. 179 *ff.*

(13) —— (1901). 'Über dem Traum', *G.W.*, **2–3,** 645–700; *On Dreams*, transl. M. D. Eder. (London: Heinemann, 1914.)

(14) —— (1904). 'Psychopathology of Everyday Life', in: *The Basic Writings of Sigmund Freud*, transl. and edited by Dr. A. A. Brill. (New York: The Modern Library.) Pp. 33 *ff.*

(15) —— (1925). *An Autobiographical Study*. Transl. James Strachey. (London: Hogarth Press, 1936.)

(16) —— (1927). 'Postscript to a Discussion on Lay Analysis.' Transl. James Strachey. In: *Collected Papers*, **5,** 205–214.

(17) —— *Aus den Anfängen der Psychoanalyse. Briefe an Wilhelm Fliess (1887–1902)*. Herausg.: M. Bonaparte, A. Freud, E. Kris. (London: Imago Publishing Co., 1950.)

(18) JELLIFFE, SMITH ELY (1937). 'Sigmund Freud as Neurologist', *J. Nerv. Ment. Dis.*, **85,** 696–711.

(19) WITTELS, FRITZ (1944). 'The Cradle of Psychoanalysis', *Amer. J. Psychiat.*, **100,** 521–528.

REFLECTIONS ON THE FUNCTION AND ORGANIZATION OF A PSYCHO-ANALYTICAL SOCIETY

By JOHN RICKMAN, M.D. (LONDON)

1. Introduction 218
2. A brief survey of the field 218
3. An experiment in co-operation between organizations 222
4. An arbitrary classification of research areas in the field of psychology 223
5. On the nature of a profession 223
6. An approach to the Sociology of Psycho-Analysis 224
7. Will the former opposition to analysis return? 225
8. The distribution of psycho-analytical publications 228
9. On the presentation of papers to a psycho-analytical society 228
10. On the oral tradition in psycho-analysis 234
11. A personal note about the organization of a psycho-analytical society . . . 235
12. Table showing membership and Associate membership, medical and lay, in 1932 and 1948 . . . . . 236/7

1. *Introduction*

Next to a total lack of contributors and of subscribers nothing is more dreaded by an Editor than that the organization he serves should establish a precedent that Addresses from the Chair and such-like speeches for An Occasion should be published in his Journal. Knowing this both as an Editor and as an ex-President of one of the Branch Societies of the International Psycho-Analytical Association (the British one) I have tried to avoid embarrassment to the Editor and I hope to readers by removing from the Addresses from the Chair given in July, 1948, 1949 and 1950 all references to current events which do not have a general bearing, and am placing before the readers of this Journal some Reflections which, though based on the experience of only one Society, may perhaps have a little significance for all.

It is proper at this point to say that to remedy such defects as are apparent to me in the three original Reports I have revised them and in places added to them considerably. Naturally I offer them with hesitation because they are discursive and do not derive exclusively from that area of research which it is the profession of psycho-analysts to explore.

Readers are kindly asked to imagine themselves to be members of the British Psycho-Analytical Society in the reconstruction phase following a world war—a Society which has grown in numbers to about one hundred with about fifty students; also to realize that among the students in one year there were more Lieutenant-Colonels than any other category, i.e. that students and members had been busily and responsibly employed during the years of war struggle in many and diverse psychological duties; also to recall that the Society is about thirty years old, its Institute (the organization which manages its Trust Funds, arranges for the housing of the Society, the Clinic and the Library and the Training) is twenty-five years old and is undergoing a reorganization in order to enable it to function more efficiently under the wide and generous regulations governing such Charitable Organizations in England.

2. *A brief Survey of the Field*

A survey of psycho-analysis in the first fifty years of its existence cannot be separated from a consideration of the field of forces in which it operates. In a world that has changed so much in the half-century, it is surprising to discover how little in essentials psycho-analytical work has altered in that time: the use of the simplest concepts—how profound and revolutionary they are, we are still daily discovering—those concerning our capacity to translate unconscious processes into conscious ones (or to undo the

dream work and symptoms and see what lies beneath) and our ' social instrument ' of research (the transference situation) have undergone but little fundamental alteration in this period of world-wide transformations. Freud laid his foundations well, and fortunately for us lived long to build on them.

Though the essential work of analysis has not altered radically (and to say this is not to deny the extension of theory and practice but rather to afford a criterion for distinguishing the continuity and fundamental identity of all psycho-analytical work from that in other fields) the direction of pressure exerted by the community upon psycho-analysis has changed a very great deal. We all know that formerly to be a psycho-analyst was to be thought an oddity: it was a hindrance to professional progress, and all of the propulsion in the psycho-analytical direction came from within the persons concerned. A group of people reckoned as eccentric is never given professional status, they are thought of as outsiders. To-day, within a generation, the situation has largely changed. Professional status is expected of us —that we know by many and by no means small signs—and the Institute has to face that pressure.

The reason for the change in the public and professional attitude to psycho-analysis lies in the fact that the analysts have in their research and therapeutic technique an instrument of great power: what happens in their consulting rooms will give a new direction to the thoughts of mankind. Though hardly more in number than one in a million of the population, what lies within the field of the analyst's field of research will eventually influence that million. We may therefore with seriousness and in all modesty give consideration not only to the phenomena which it is our professional duty to explore but also to the sociological aspects of our work. We may be sure that if we do not consider the sociological implications others in some ways less fitted for the task than ourselves will do so. This is justification enough for considering the function and structure of the psycho-analytical society, which will here be examined mainly as a means for fostering and transmitting ideas relating to what seem to me to be the essentials of psycho-analysis.

The concept of the transference situation is one of our great inheritances. It is a social situation demanding the utmost of the two participants, and it is to be expected that the use that is made of that research and therapeutic opportunity will never be quite the same in any two decades, or perhaps even in any two years. It is also to be expected, and the event justified the surmise, that the inferences drawn from behaviour in that situation will vary from individual to individual. A new idea, a re-viewing of an old idea, will change the pattern of behaviour in that situation, if the idea is real—i.e. if it has effects.

Transference (and counter-transference) deals with forces within the participants which have not established perfect equilibrium and are in conflict with one another. It is a situation calling for constant vigilance. Vigilance is a part of the analyst's habit of mind, and in this task he is considerably aided by a social institution which keeps before him a useful mirror reflecting both himself and the contemporary world of similar experience, viz. the discussions in the meetings of his psycho-analytical society. They are few in number and heroic in endurance who can thrive and remain supple without the aid of these colleaguely meetings; perhaps even research workers, except those of the highest flight, benefit from them. The clinical discussions give opportunity not only to acquire new ideas and to see new meaning in the old ones, but also for the listener to feel his way into the relation arising between another analyst and his patient, to penetrate the boundary wall of someone else's consulting room.

The differences in behaviour in the transference situation which discussion discloses are one of the healthy signs of our work. Discussion of these is fruitful in proportion to the energy given to the task of seeing just what tools of his trade the speaker is using and how fully he is using them; it fails in usefulness if not guided by a friendly participation in the *total situation* being disclosed.

Though differences in behaviour in the transference situation are to be expected and their discussion welcomed, the institutionalizing of these differences must be undertaken with considerable caution by the group, and with an equal hesitation by the individual. The corrective to the tendency to institutionalize differences, as far as the group can influence the attitude of the individual, lies in the conduct of the scientific discussions, particularly of case material. The mental participation in the analytical work of a colleague is a very personal affair. It is based on an identification with him in the doctor-patient relation being dis-

cussed; it involves an understanding of his frame of reference with a full and lively sense of its potentialities as he himself feels them—only after this full participation within the speaker's frame of reference can the listener profitably add his own opinion to the discussion, or to a wise consideration of the topic.

There is probably no field of activity more difficult to discuss intelligently than ours: the material itself is elusive, the observation of the material is not shared by another person, and the concepts employed in explaining a class of phenomena never provide enough dimensions to enable the events to be given a final ' placing ' in the world of human experience—the marvel is that our discussions are as fruitful and as coherent as they are. They are useful in proportion to the energy given by those participating in the acquiring of new identifications and different frames of reference to the problems we meet in the isolation of our own consulting rooms.

The scientific meetings, however, provide another and perhaps not lesser benefit. They can, if the assembled members are so minded, provide a ' climate ' favourable to the germination of ideas. The great pioneers, to be sure, do not need this—they are capable of producing superb work without such aid while the majority cannot—but everyone likes warmth of heart towards his ideas, and is fortified by constructive criticism.

In the preceding paragraphs there has been a transition of topic from the transference situation to discussion in the scientific meetings, rather as if there were a close connection between these two kinds of social contact. It is just this connection which gives a special quality to our scientific meetings and which makes them so different from other kinds of discussion groups. The common experience, the starting point and reference point of the whole work and movement is the same, or nearly the same, to all analysts, and only analysts can share it.

All that has been said so far concerns a group of people who need have no organization binding them together, indeed they need not have met personally; the communication is through the medium of the common experience of handling transference phenomena with the aid of the simple but penetrating ideas given us by Freud. This is always the position of a new and unprofessionalized, of a creative but not potentially unstable, community: but it lacks organs of contact.

The problem before every growing psychoanalytical group, sooner or later—and they all seem to grow, though some may be destroyed—is that of retaining the fresh and intimate exchange of ideas on the scientific side while developing a structure capable of resisting internal and external pressures. It may be an insoluble problem, but it is not wise hastily to assume that this is the case. It probably requires the analogue of the analyst's vigilance—the Society's or Institute's self-examination, making sure that it is conducting its affairs so that its creative potential is given the greatest means of outlet and its organization only the attention needed to keep it supple and responsive to changes.

An organization such as ours passes through two phases. In the first, while it is struggling into existence, it is mainly concerned with the problems of its own maintenance; in the second phase, the one in which we now are, its own maintenance is assured, but it becomes an organization of which is demanded satisfaction of the needs felt not only by the individual but by other organizations.

It is becoming evident to a number of people outside our society that the training which the Institute provides gives the person so trained something which even a personal analysis does not supply. One reason for this may perhaps be found in the earlier paragraph of this paper when considering the relation between work in the consulting room and discussions in our scientific meetings. Our training affords practice in the process of making identifications with people who are in this special kind of social contact we call the transference situation, i.e. people so trained acquire a flexibility probably not to be obtained by any other professional means. The student analysand takes on a case under supervision while he is himself undergoing personal analysis, and this gives him an opportunity, denied to the patient coming for therapeutic analysis, to feel the operations within the transference situation from both aspects more or less simultaneously. It is this duplication of rôle in a situation which deals with the inhibition of growth and stability (i.e. which examines the hindrances to the development of emotional relationships in new situations) that puts the person trained by us in a position of greater demand than those who are only analysed by us. This double experience of being analyst and analysand gives a specially

clear occasion to become aware of the interplay of forces, positive and negative, conscious and formerly unconscious, working to the consummation or disruption of the projects in which he is participating.

In years gone by we reckoned it an advantage to our science that a few of our members should be interested in anthropology, education and others of the mental sciences. The theories we receive from Freud we thought should be carried into fields other than the therapeutic so that a broader basis could be given to our understanding of human affairs. In recent years, and stimulated by war, which promotes experiments, attention has been given not only to the application of psycho-analytical theories, but also to the observation of the tensions and conflicts occurring in specially created temporarily closed communities (the analytical transference situation being an instance of a temporarily closed community, albeit of only two persons). It is too soon to speak of the theoretical outcome of these investigations, but they have already yielded some interesting and encouraging practical results.

According to those who were responsible for the technical work involved the following enterprises owe a part, and in some cases a considerable part, to psycho-analysis: the War Office Selection Board, the Civilian Resettlement Units, certain Group Therapy experiments, and numerous technical procedures for assessing and promoting a good military morale. Since then some of the underlying ideas in those experiments carried out during the war have been applied, and are being increasingly applied, in the civilian field, so much so that it would be no rash prophecy to say that in ten years' time, if we were so minded, we could fill as many candidate vacancies in lay non-therapeutic fields (that were never before the war considered particularly relevant to psycho-analysis) as we now give to medical therapeutics.

In addition to the new fields of enterprise, we are being asked to train psychiatrists whose life work will probably lie in mental hospitals and psychiatric out-patient departments; this is in itself nothing new, but the increased emphasis under the National Health Service on full-time service will inevitably change the later professional life of a number of our candidates.

Dealing with this last group first, it would not be expedient to make any restriction on the post-training activities of our candidates, rather should we welcome the opportunity for research and therapy in a branch of psychiatry which is so difficult and which needs such clarification as we can bring. The State Medical Service may indirectly and by inadvertence, one might say, induce us to have a special or advanced training in the psychopathology of the psychoses, mental defect and delinquency—a development that would be indirectly helpful to child and to adult therapy.

Returning to the training of lay persons who will take up non-therapeutic activity, the three following points merit consideration: first, a welcome should be given to enterprise wherever it is found; we do not know what additions to knowledge, or to our science in particular, may come from such enterprise; secondly, since there is pressure on our teaching staff, it is expedient to conserve a good proportion of people who will do clinical work over a long period of years (it takes years of clinical work before an analyst is fitted to be a teacher of analysis and no amount of theory reading or work outside the consulting room can substitute for that done inside it): a clinical cadre is necessary to keep the teaching going; therefore, thirdly, only a small proportion of the applicants who may spend their post-training years in the non-clinical field should be admitted to our training. It is assumed that these considerations only affect the selection of candidates, and that the Institute will continue its policy of not laying any obligation on its candidates to undertake any particular activity after they have passed the course. In this respect we are educators, not directors of labour.

In 1948–49 the National Health Service came into operation and the Act of Parliament founding it gave the Minister of Health the right to 'claim' any hospital or clinic which might be useful to that Service; the Act also gave the Governing Bodies of the hospitals and clinics thus claimed the right to petition to be 'disclaimed': it was an honour to be claimed and a privilege to be allowed to be disclaimed. After much deliberation it was agreed to request the Minister of Health to 'disclaim' our Clinic. This he has done, but it may be put on record that our request to stay outside the Health Service was looked on with regret by a number of psychiatric colleagues in the region into which we would have been drawn.

The attitude of our psychiatric colleagues is cordial, their interest in our training is one of appreciation and they wish to have our candidates in their hospitals. This is satisfactory as it means our students will be given facilities and not as formerly discouragement when they come to our Institute to study.

3. *An Experiment in Co-operation between Organizations*

In 1921 a proposal was made to the Governing Body of a world-famous Mental Hospital by a candidate for the post of Medical Superintendent that the patients should be put in a ' climate ' or ' social field ' where everyone had been analysed, i.e. all the persons in contact with a patient (not only the doctor in charge of his analytical therapy) would be in a position to recognize and not be unduly reactive to the deeper sources of conflict which heavily influence the behaviour of the patient; thus the expression of the patient's troubles would be less hindered by lack of understanding and he would not feel so socially rejected. To begin with, the experiment would be confined to a single ward, much later perhaps to the whole hospital. It may be worth noting that the candidate was not given the post for other reasons than his enthusiasm for psycho-analysis ; indeed about twenty years later the unsuccessful candidate was asked by a member of the Governing Body of that Hospital if he had been able to carry out the project elsewhere —the idea had certainly not been forgotten.

Without the members—save one—having any knowledge of this episode this Institute has come near to fulfilling this project. Within the Candidate-intake over a period of nearly two years a large proportion came from the Tavistock Institute of Human Relations and the Tavistock [Out-Patient] Clinic, both in London, which for our present purpose may be considered to be the same organization. Our Institute invested heavily in the training of practically all of the senior staff of this organization. This was done, as the saying is, ' without strings attached ', i.e. as in medicine, the law and the Church, those responsible for education make no conditions regarding the use to which the training will be put, neither did our Institute.

The return to psycho-analysis from this large investment of time and money will in part be direct in that there will be an increase in the number of practitioners of psycho-analysis, in part indirect in that the application of dynamic psychology to areas of human science other than the treatment of patients will, because it adds to psychological knowledge, facilitate combined research. Although psycho-analysis is based on the transference relationship in its direct research area, it is part of the broad progress occurring in the human sciences which includes direct research in relationships, equally complicated, in the function of groups.

Such experiments as the one mentioned above, which was only partly in the clinical field, cannot be lightly undertaken nor can they be often repeated because the centre of psycho-analytical research—this is both its strength and its limitation—is that it is a two-body situation, so that most effort must be given to the direct development of the potential of that situation. But there is scope for the application of intensive co-operation with other organizations without leaving the strictly clinical field. When only ambulant patients are taken on for a particular kind of treatment, which is nevertheless suitable for non-ambulant persons, there is necessarily a restriction in the scope of the research afforded by that treatment. So it is satisfactory that an important proportion of our training and clinical effort can flow into the Cassel Hospital where psycho-analytical treatment is given to In-patients, many of whom need hospital care at some time in the course of their illness, and who, following discharge from Hospital, can be treated as Out-patients by the same doctors.

The association of our Institute with the Tavistock and with the Cassel Hospital is not an affiliation in any formal sense, it is one that is purely functional and not structural. It is therefore of a type which can be extended or diminished as occasion demands without altering our independence and without restricting our liaison with other institutions. These points are very important. With regard to the National Health Service, though in some ways we may lose by staying out, we gain only in proportion to our freedom to give in directions where our contributions have most scientific power; in assessing this we have always to reckon on the cumulative gain where several workers of like mind and training can form a ' climate of opinion ', an atmosphere in which new and incompletely formulated ideas can germinate.

One feature of the two organizations named of outstanding importance is the emphasis

placed by them on the 'feed back' process in group dynamics, an operational idea and action derived from psycho-analysis, which with its transference interpretations is *par excellence* a 'feed back process' in a two-person relationship.

4. *An Arbitrary Classification of Research Areas in the field of Psychology*

As has been said elsewhere and in various contexts [1] the field of psychology may be broken up into areas according to the number of persons essential to the research under consideration. Thus introspective psychology, the psychology of the special senses, of reflexes, learning processes, etc., may be called a One-Body psychology. Psycho-analysis is a two-body psychology with an immense lot to say about three-body dynamics and about sibling relationships, making a four-body psychology. But when we come to five- (or multi-) body dynamics the psycho-analyst has less *direct* evidence to work on, in fact as psycho-analyst he has almost none at all.

(Freud's excursion into group dynamics was almost exclusively confined to the derivatives of the œdipus situation, i.e. to parvi- not multi-body dynamics). If we look at this arbitrary schedule more closely we see that predictions as to behaviour become less certain as we make inferences from a lower to a higher category; thus who would, from the basis of laboratory research into one-body psychology, have predicted the findings of the two- and three-body transference phenomena? Again a knowledge of one-body psychology is an aid to the understanding of the early stages of ego development (when one-body processes are paramount), but who can say to what extent the later phases of the ego's development are not influenced, perhaps largely, by multi-body dynamics, which is outside the range of *immediate* observation of the psycho-analyst?

Such considerations as these come to the mind when reflecting on the policy of our Institute when it invested its educational resources so heavily in the enterprises of the two organizations previously named.

It is impossible to predict, perhaps for a decade, what the outcome will be of having a *group* of persons trained in academic psychology, psychiatry and professionally concerned in group dynamics who are also trained psycho-analysts. Our Institute has made an experiment which may not be repeated for years, but it is in keeping with a broad, and may one be so bold as to say 'university-like', policy of education to encourage integrative studies provided that these are based not on armchair speculations but on the acquisition of professional skills by research workers in several psychological disciplines. Our Institute, however, may have to endure the reproaches of those who say we scattered our resources too widely. One thing is certain—it is impossible to predict where the growing points of science will next bud out; and one thing is imperative—creative imagination, no matter how inconvenient to our complacency, must be given the fullest scope.

5. *On the Nature of a Profession* [2]

The demand for persons trained in psycho-analysis leads to the questions: what is a professional man and has psycho-analysis any right to call itself a profession?

A professional man is a person (i) who has submitted himself to the discipline of an education in the theory and practice of his occupation by the teachers of that occupation; (ii) who, when himself a practitioner, will endeavour to correlate what discoveries he may make with the body of knowledge formed by his predecessors, his teachers and fellow practitioners, and will keep no discovery to himself but will share it with his colleagues; (iii) who, when he has reached a sufficient level of maturity to be made a teacher of his profession, will withhold no knowledge from his pupils so that the next generation will be at least as widely and well informed as he is himself; (iv) who, when in a difficulty of a professional nature, will call in a brother practitioner stating his problem fully, and if consulted by a colleague in such circumstances will give the best advice he can, keeping nothing back, and will not try to take away his colleague's practice from him in respect to the case in question, and (v) who submits himself to the ethical code of his colleagues in respect to his relations to his clients and colleagues.[3]

---

[1] E.g. in the *Journal of Mental Science*, *British Journal of Medical Psychology* and the 60th Birthday Commemorative volume to Geza Roheim (none of it published at the time of this writing).

[2] This section was not included in any of the three annual presidential reports referred to in the Introduction.

[3] In the case of the Medical Profession there is a feature which is not found to the same extent in the others and that is the sense of personal responsibility which the practitioner should feel for the welfare of his

This five-fold definition links the generations of teachers, practitioners and students and is based on the relationship between equals and includes an ethical code; it applies widely to doctors, lawyers, priests, architects, but it will be noted that it does not include a Professional Register. How far does it apply to psycho-analysts and if so at what stage in its development can psycho-analysis be said to have started to be professional? Clearly on this basis psycho-analysis could not have been called a profession before the systematic training began to link the generations since such cultural transmission is essential to the definition. The question arises whether since there are medical and lay analysts there is no true equality among colleagues which the definition demands? The definition does not lessen the status of lay analysts because point 4 speaks only of referral within a group who share a common training and an ethical code. The fact that the lay analyst is under an obligation to keep in touch with the referring doctor does not put him in an inferior status since there is the same relation existing between consultant or specialist and the referring general practitioner.

In one sense psycho-analysis is not in and of itself an independent profession *vis-à-vis* other professions, for it is dependent on medical practitioners for its professional status, but within the orbit of the medical profession it can be regarded as a profession on the basis given in the definition. There remains to consider the Register Question. Who has the privilege of compiling a Professional Register and for whom is it compiled?

Clearly the only persons who can compile a professional register are those who have to educate the students and to assess their technical competence; but this answers only half of the question—an equally important thing is, who will recognize the register when compiled as having any social or professional significance? A register is not compiled for delectable perusal by those whose names are on it, but for the scrutiny of those who are excluded from it. The people who refer to the list of psycho-analysts is steadily increasing in number and in range of professional interests. Recognition of the List or Register is a slow—rightly a slow—process which has to be earned by those whose names are on it; the earning of recognition is done by the establishment of a high standard of training and assessment of professional competence and by the maintenance of a strict ethical code.

6. *An Approach to the Sociology of Psycho-Analysis*

Only those who make dreamland their habitation can dispense with a view from the window; those poor souls who are responsible for an organization in a quickly changing world must upon occasion look about them. One way of doing this is to follow the ways of thought of the sociologists.

In the United Kingdom there are at the moment about seventy-five psycho-analysts in therapeutic practice (a few have retired or are in non-therapeutic activity). That is roughly one for every 650,000 of the population. If we compare this with other occupations in which there is a fairly intimate personal relation between the professional man and his client we have the following comparisons (the figures are only approximate). Psycho-analysts 1:650,000; Medical Practitioner, 1:540 (this does not take into account the many doctors who are not in clinical practice, e.g. married women, those engaged in physiological research and in clinical laboratories, in administration, etc.); Solicitors, 1:2370 (again this figure is too low because many qualified solicitors have no personal or client relationship because they are employed in administrative posts, etc.); Church of England clergy (this is a very difficult figure to compute): about 1,850,000 people take Holy Communion in Easter week according to the rites of the Established Church, and there are about 25,000,000 on the nominal rolls of that Church; there are about 40,000 ordained Anglican clergy, but many of them are schoolmasters, are retired or do no parish work—1:625 is perhaps a fair figure for present comparison; in the Ministry of the Methodist Conference 1:168 (but this figure is again too low because it includes 'supernumerary ministers'); Roman Catholic priests about 1:400. (The ratio for the Jewish faith is at

---

patient. The problems raised by State Medicine, in which the practitioner has two masters, have not yet been solved, nor have they been discussed at any length or depth by psycho-analysts, perhaps because our conception of one of the parties to this problem—the State—must remain somewhat confused until such time as there is formulation and then clarification of multi-body psycho-dynamics.

present difficult to compute because of the movement of population after the Nazis came to power.)

Turning to the medical profession: it has been suggested that the Psychiatrist ratio should be 1:25,000 or about 2,000 for the whole of the United Kingdom. (I give this figure because it has been used, though not officially endorsed, in high-level administrative discussion; it seems to me too low.)

When considering these figures it is prudent to take account of the rate of increase that is practicable as well as the number that is desirable. Psychiatrists, and still more so, psycho-analysts, take a long time to produce; but whereas a fairly large increase in the number of psychiatrists can be made without overburdening the teaching staff, in the case of psycho-analysts this is not the case because the training of each student takes about 1,000 individual tutor-hours—a time factor without parallel in any other profession.

The table of the world distribution of psycho-analysts (given at the end of this paper) does not disclose the interesting distribution within the countries named therein. If we assume, as indeed is reasonable in respect to private practice, that a psycho-analytical livelihood is not likely to be made except in fairly large centres of population and that since that livelihood must be made out of annual fees from each patient amounting to about one-eighth of the analyst's gross earned income, then it follows that the *size* of the population in the centre where the psycho-analyst settles is not the only, or indeed the main criterion; the more important criterion is the number of persons with a surplus income over immediate needs or a capital sufficient to support one-eighth of a psycho-analyst, so to speak. If these basic assumptions operated alone, one would expect in the case of the United Kingdom that the distribution of practising psycho-analysts would be roughly equal in the metropolis and the rest of the large industrial and academic cities put together, for these in number and in wealthy citizens are together nearly equal to the figure for London; in fact the proportion is about 70 to 5 in favour of London. If we examine the distribution in other countries we find that in 'decentralized' countries like Switzerland (cantonal organization and loyalties) and the United States (one of the most politically and economically decentralized of all highly industrialized modern states), the analysts are fairly evenly spread over the centres of urban wealth; in Holland, which culturally has been largely influenced by rival cities of roughly equal wealth and power, the analysts are (or are rapidly becoming) spread according to urban wealth; in France, as one would expect, the political prestige and economic domination of Paris is reflected in the distribution of the analysts. (Austria and Hungary before the Second World War came under the same category as France. Germany, before the Nazi *régime*, was on this reckoning about midway between France and Switzerland but with an analytical distribution nearer to the former.) In addition to the cultural factors already mentioned as influencing the distribution there are probably others both of internal and external origin; the former would include the cultural habits of the personnel concerned (e.g. perhaps a certain tendency to gregariousness found among Jews) and on characteristics of the leadership of the pioneers of analysis in the various national or cultural areas. The factors of external origin would include the influence of the extravert culture of almost purely industrial cities on the rate of assimilation, or rejection, of such a point of view as that of psycho-analysis which has 'nothing to show for its work' and which deals with disorders which cannot be seen post-mortem. Another such factor is the tradition of university leadership or professional prestige. In the industrial cities of England, for instance, this is low, in Scotland very high, but despite this fact there is only one psycho-analyst in Scotland. This tardiness on the part of Scotland—so forward in every branch of scholarship, of psychology and of medicine—is a strange phenomenon which has not yet been explained.

The psychological aspects of the uneven spread of psycho-analysis seem to me to merit attention, indeed their neglect—among psycho-analysts of all people—should itself make us wonder why there is this unmindfulness of serious issues.

7. *Will the former Opposition to Analysis Return?*

In its early days psycho-analysis met with a certain amount of opposition, and some psycho-analysts think that the present phase in which psycho-analysis receives a certain amount of recognition will give way to a return to disfavour. This general opinion cannot be disproved since it concerns the future and because it

does not specify the new cause, or give reason for the return of an old cause of disfavour. It might be argued with an equal or even greater plausibility that the disfavour which was once accorded to psycho-analysis will move to another study of dynamics, viz. those of the group.

The opposition to psycho-analysis in those far-off days was in part due to the disturbing nature of the ideas themselves, in part to a certain tendency among the exponents of our subject at times to place less value than usual upon tact when presenting startling opinions or in dealing with opposition. Indeed psycho-analysts occasionally gave the impression that they were even more persecuted by their opponents than in fact was the case. The patience and discrimination which they possessed when confronted by resistance to new and unpleasant ideas in the consulting room were less easy to attain and maintain in scientific societies, public debate and in published writings.

We may surmise that among the reasons for this state of things one point of importance was the fact that the intimate two-person relationship of analyst and patient gave a limiting pattern to psycho-dynamics as it was then understood, and in those early days we must also remember the frame of theory for the dynamics of conflict was thought to be adequately resolved by reference to the Ego and the Sexual Instinct. With the introduction of the notion of the Super Ego a new dimension was given to theory and—unless I am mistaken—an increase in tact in respect to the public behaviour of psycho-analysts when in debate. I.e. before *Group Psychology and the Analysis of the Ego* appeared the technical guidance which the analyst received from theory was concerned with individual and two-person dynamics on the one hand and on the other with quite general anthropological speculations (*Totem and Taboo* for instance) and not with the dynamics of face to face relations within groups. In other words in those early days the technical guidance from theory was quite inadequate to deal with such opposition as came from organized groups or society. It was at times a matter of surprise to me not that the opposition was so severe but that it was so restrained.

Another reason why the tact of the psycho-analyst in the consulting room lessened somewhat outside it lay in the fact that when in consultation the analyst and patient were both aware—at least at times—that they were involved in a joint investigation, a sort of family situation, and although as everyone knows there are things which upset families, there are also things which make this ' in-group ' feeling an important force. The professional bond between the analyst and patient was reinforced by a special kind of in-group tie. Before the accession to theory from Freud's exposition of Super Ego psychology it was hardly possible for the psycho-analyst to orient himself to a group in at all the same way as to a patient if *he were using his theory as his only guide* : for his theory had no place for group ties. There was yet another thing of importance ; apart from the fact that the exponents of the new ideas were regarded as threatening the prestige and economic security of those who were content with pre-analytical psychiatry, the analysts were thought of as merely unprofessional persons, mere free-lance raiders without a sense of responsibility. If it were not for the organization by various psycho-analytical societies of systematic and rigorous training programmes the opposition to psycho-analysis on grounds of its free-lance character would in my view have lasted much longer, indeed might have lasted indefinitely.

The reader will have noticed that there has been a shift of emphasis from public opposition to professional opposition ; that difference must be clarified. In what may be called the free lance days, before psycho-analysts took steps to become professional (in the sense outlined in section 5) all opposition was ' public '. Because the ideas presented were objectionable it was thought proper to attack them and the exponents of those ideas could be picked out for oprobrium one by one or be lumped together as a nasty muddle of misguided people; at gatherings of learned societies it was not thought necessary to use learning, reason or even courtesy as weapons against the new psychology. When however, the psycho-analysts showed not only clinical acumen and effectiveness, not only expounded penetrating but useful and coherent ideas, but also could organize themselves without external support and command loyalty to their organization, then the organized professions were faced with a structure they could understand, and with a discipline they could respect and even envy. In all of this no mention is made of the content of analysis to which exception was taken. Its emphasis on the influence of sex in neurosis and everyday health, the

worse than bawdy notion that children not only suffer perturbations of libido but even experience enjoyment from it, the pangs of incest, the overriding of untrammelled wishful phantasy by the constraints of a determinist philosophy—all of these factors played their part and have been discussed by psycho-analysts for years.

The effort which psycho-analysts give as a matter of course to patients who resist the analyst's endeavours to elucidate their problems finds warranty in psycho-analytical theory, but our theory does not cover at all adequately the dynamics of group relationships ; we must therefore acknowledge that we cannot predict with any degree of certainty whether psycho-analysis, now that it is an organized body, will meet with anything like the severe opposition it once received. (It was said of the Reformer—it is not true of the Revolutionary—that he has only one certain ally, the Angel of Death, who removes to safer spheres those who oppose his reform—leaving the ground clear for those who with changing circumstance may not need that particular reform any more.)

The question whether or no the opposition to psycho-analysis will return can be viewed from another aspect. When psycho-analysis was born the organization of society and its various institutions seemed fairly safe, world wars had not seemed possible, revolutions of any importance, in the larger countries at any rate, had not occurred for half a century and the Individual—that product of the Italian Renaissance—was thought of as an isolated Special Creation personally related to his God, personally endowed by God with Conscience, answerable to God for the exercise of his Will, a Master of the Microcosm, the self. Psycho-analysis weakened these illusions and reinforced other influences that were working towards elimination of absolutism in personal and political concepts. Psycho-analysis was also regarded as a threat to the stability of society because the very illusions it weakened were thought to be essential parts of the structure of society, though they were not of course seen to be illusions.

Two world wars, several revolutions, and the rise of fanatical ideologies, have forced upon modern civilized man the need to re-examine the foundations of his corporate existence. The study of the Individual's weakness holds less terror now, indeed it is often thought of as a relief from the strain of enduring our unstable economic and political lot. What is thought of as dangerous now is a study of the shaky foundations of the institutions of society—if *group* disruptiveness is brought to light then nothing is secure. On this ground among others the focal point of the public apprehension may well have shifted from psycho-dynamics to socio-dynamics or rather to a study of those forces which result in disruption in the areas of group action.

Painful ideas can be endured if they can be put in an abstract form, but if they are considered in a ' social enclosure ' they are greatly dreaded. Psycho-analysis works in a social enclosure and a small one at that. The events in what has been called ' the here and now ' (the analysis of transference phenomena is another name for it, though not a synonym) are by analysts made the chief if not the only topic of consideration from which they allow no escape ; ' there and then ' studies (such as psychiatrists commonly employ) are considered less dangerous because tensions can be dissipated without being fully faced. The studies of group dynamics made by those who have been trained in or influenced by psycho-analysis, have the ' here and now ' quality of immediacy and inescapability and are dreaded. The organization that calls in the student of group dynamics has a comparable dread and for probably basically the same reasons as had the patient in days gone by who sought the aid of the psycho-analyst. Students of group dynamics will in my view get the brunt of such attacks as used to come to us ; in terms of social danger we are not only safe, we are safety valves. But if we turn our considerable experience of unconscious processes to a study of the intra-group tensions within our own society (the risk of our doing this seems to be small) or to a study of tensions in other face-to-face groups then we shall get a return of public disapprobation, but in my view not otherwise.

The dynamics of a multi-structured group is as yet without its Freud ; it lacks a conceptual frame of reference which is both useful and resilient, its analogue with metapsychology is vague and shapeless, it is possible that psycho-analysis as such has not much to add to this branch of the human sciences, but it is likely that a training in psycho-analysis will always be an advantage and may in time be considered a prerequisite to its professional study. Anyway, if there is a tendency for psycho-analysis to return to disfavour we shall have trained

allies in the field of socio-dynamics to warn us and advise us in difficulty—that is if we reckon other human scientists as allies worthy of our confidence.

8. *The Distribution of Psycho-analytical Publications*

Speaking only of the United Kingdom and during the twenty-five years of the Institute's existence the number of psycho-analytical books (including separate issues of the Journal) is over a quarter of a million. It goes without saying that these are not distributed evenly over the population but at least 50,000 homes have a copy of one or more of Freud's books in them. Probably one in 500 of the population has read one or other of Freud's books. About a half of these book purchases have been made since the beginning of the second war, and this at a time when book and journal production worked under the severest handicaps of paper restriction, deflection of labour to war purposes and bombing.

9. *On the Presentation of Papers to a Psycho-analytical Society*

Any audience, scientific or popular, is composed of two kinds of people, those who grasp new concepts most readily from reading and those who take them in best by means of verbal, more especially spontaneous communication. The two types are here described in extreme form, there are of course mixed types, and also people who vary according to content or other factors in the matter under discussion. Neither of these two types get the best out of the method of presentation usually employed in the larger psycho-analytical societies.

A paper delivered to our Societies is usually written with a view to publication and is read almost verbatim from the script. The written word differs from the spoken one. (Royal Commissions permit their witnesses to do a moderate amount of editing of the style of their evidence—though not of course the content—otherwise the text would be almost unreadable, though when verbally given it was understandable ; similarly many papers, excellent in print, are ' unhearable '.)

This is a well-known fact, and its importance is endorsed by the remarks made in the subsequent discussion that the hearers of the paper, even the ablest and most experienced ones, would like to read the paper before giving an adequate response to it. This is not the only objection to reading from script. Those who deliver from a typescript seldom take the precaution to get advice on how to deliver a paper. Any radio producer will say that the slight pauses in conversation do not always come at the full stops of written constructions, and that the rhythm and pitch of delivery must not be taken from the harsh parallels and spacing of the typewriter. In over twenty-five years of listening and editing I recall only two papers which read well in print and ' heard ' well in the lecture room. The late Ian Suttie's typescript was scored like a sheet of music for time and stress, a most artificial looking object and yet when delivered it flowed with an easy grace to the ear and when printed without his scorings it was agreeable to the eye ; the other was from the late J. D. Unwin who took the trouble to learn his paper by heart and spoke with a spontaneity that astonished only the few who had the galley proofs before them.

This is not an unimportant matter. A paper delivered occupies during the evening from fifty to a hundred listener-hours ; these good people assembled have a concern that the occasion should be fruitful and give their best ; too often the narcissism of the speaker, or a clumsy convention, hinders the occasion's proper development.

To the proposal that papers should be circulated in advance, it has been objected (*a*) that only a few coming to the meeting would read them, (*b*) some would read them instead of coming to the meeting, (*c*) that it is hard to get a paper written two weeks in advance of a meeting, (*d*) the prior circulation would spoil the uniqueness of a first delivery, (*e*) that when the content of the papers delivered is case material it is undesirable to have it in unrestricted circulation.

The last cannot be gainsaid, but the clinical parts could be reserved for the evening itself. The uniqueness of first delivery is not to be refuted because the first is always unique ; what is important is the effectiveness of the delivery. (Perhaps analysts may unwittingly identify themselves with Freud who gave many of his greater papers to the Congress—but he did not read them, and his power of clear conceptualizing and graceful phrasing in writing and in verbal delivery were exceptional. Freud, by the way, likened verbatim delivery from a manuscript to a person inviting his friend to accompany him into the country, and then he himself rides in a carriage while his

friend trudges on foot—it cannot be expected that there will be an easy companionship on such a journey.)

The first three objections to prior circulation of papers also concern the matter of morale, or rather a ' negative morale ' within the Society. If this be so the state of morale is worth attention and the causes of the weakness should be sought. But there may be two other reasons why there is a wish to have typescript papers read aloud, the one is a simple wish to be read-to, a carry over from an earlier, a much earlier, experience, i.e. a revival in a multi-body situation of the two person relation of mother and child. And then, reverting to the morale question again, it is possible that the shared experience of submitting jointly to a verbally delivered statement acts as a ' group-cohesive ' when the group attains a certain size. It is worth considering whether the increasing size of the group does not call for increasing demands for evidences of group cohesiveness of a rather formal kind. If there are not these formal evidences of unity members assembled cannot believe that the whole company is ready to assimilate the new ideas ; with some, perhaps many people, this is a precondition to the acceptance of new ideas. The foregoing is put forward as worth consideration despite the fact that in our two-body studies we cannot get *direct* evidence of it.

Some of the objections and many of the advantages of prior circulation of papers can be met if what is sent round is a formal structure, giving the references to prior work with the theme as then expounded, and at the meeting itself the speaker delivered shortly and informally and from notes how he came to the view he is now presenting, what points he would like discussed and where in his own opinion lie the difficulties which he himself has been unable to resolve. It has been objected that this proposal robs the speaker of certain of his privileges in presenting the paper as he wants. It is no part of this proposal to hamper the freedom of members, but it is important to use the occasion to the best advantage.

In the preparation of a paper contributed to one of our scientific meetings it is possible to distinguish two phases or stages. In the first the speaker has to clarify his own mind on the issue under discussion, and this we all know is usually a difficult thing to do. It is a piece of intrapsychic work which is intimately related to his own—and indeed largely unconscious—experiences. In the second phase he has to make contact with and communicate something to his audience. This is a piece of work with a predominantly social orientation, i.e. he does not speak unto the void but to human beings about whom it is an unwarrantable assumption that they and their thinking and feeling processes are identical with his own. As a part of this task of communication he has also to remember that when presenting a portion of a patient's behaviour he has to shape his description so that his audience will see much the same things as he himself saw and in the setting in which he saw them ; this calls for descriptive art of a high order because the facts we are concerned with relate to the most complicated phenomena in nature—man's behaviour. His description has to be imaginative and at the same time precise. The less effort he puts into the creative process of description the more effort will his listeners have to exert in discovering what he is talking about : facts do not speak for themselves save in a setting of clear conceptualization—this is equally true of science and of art.

There is another matter of probably great importance when considering the problems of a Society like ours : very likely two quite different needs must be fulfilled. The one is that the scientific contributions should help us to consolidate our belief in the correctness, or at least in the passing utility, of the concepts we employ (an ' establishing function ') ; the other is that the contributions should force us to unsettlement of our complacency, to a shaking of our convictions as to how right we are (a ' revolutionary function '). This is no new notion : a very well-known psycho-analyst once said that among others we needed two types of case, one which exemplified our theories and one which upset them.

A moment's reflection will show that what has just been described is also a part of the social function of Art ; there are thus considered two kinds of Art—that which consolidates the cultural achievements of its time, and a ' revolutionary art ' which breaks down conventional ways of looking at things and at life and death. Everyone will prefer one or other according to his passing need, and if he is free in mind he will at various times and crises within himself or in his environment go to both. So it may be with our scientific discussions. It may at first thought seem to be a contradiction or a strange distortion of established usage to compare the

deliberations of a scientific society with the social function of Art, but the fact is that our work is half science and half art. For the most part we do not measure, we observe and match and manipulate patterns, and this is one of the features of art. The display of this process before an audience calls for selection of data based on logical and on intuitive mental processes, and the reception of the communications by the audience calls for a high degree of empathy with the speaker's approach to his subject and an equally high degree of critical capacity for assessing what he says. As in art, so in our science, the two kinds of contribution are needed, and at any moment it is foolish to try and say which is the more valuable to *the growth of science in the world of contemporary scientists* (the italicized words relate to a single thing or process) because scientists taken as a whole, and being human, require both sorts of food.

The matter is made more complicated by the fact that a contribution may ' establish ' in one part of the theoretical field and ' revolutionize ' in another, so that what to one part of the audience seems to be satisfactory as ' establishing ', another part of the audience will find encouragingly ' revolutionary '. The discussion of the contributions in such case get confused because the praise or the blame, the positive empathy or the withholding of empathy, is not related to the whole pattern of the paper in the setting in which the speaker is at the moment working but to parts of it which the listener at the moment needs for his own immediate purposes.

The whole process is more clearly seen if the behaviour of a Committee is studied. There are always two sorts of Agendas : there is the Written Agenda which each committee member has in common with the other members; and there are as many Unwritten Agendas as there are committee members. An opener of discussion in a scientific meeting contributes to the Written Agenda, those who follow always contribute to their own, and frequently to one another's Unwritten Agendas. The Unwritten Agendas are filled with items, not always conscious, which the speaker has on his mind. Thus committees move towards, around and beyond the ostensible point of discussion, and their final resolution is a resultant of the forces centering on the Written and Unwritten Agendas.[4]

As in committees so in our scientific meetings, the discussion wanders—as indeed it often should. But there is a difference : a committee is set for action, a scientific meeting for thought. It is often pretty clear when a speaker in a scientific discussion is unwittingly trying to give the assembly a committee orientation, i.e. to action, to the thrusting forward and acceptance of one key idea, or when he is trying to extend the range of thought; in the former case he is aiming to bring every one to his own view, in the latter to widen the range of appreciation in his listeners of the manifold complexity of the subject matter being treated.

Perhaps in the foregoing sufficient stress has not been laid on the frequency with which we hear those scientific papers which, after beginning with a general survey, show the growth of the particular idea to be singled out for special consideration. It is perhaps true to say that aspiration at times exceeds performance, and that what to one listener seems to be a completely satisfactory account of the development of psycho-analytical thought on the subject discussed, to another seems one-sided and inadequate. There is probably no branch of science calling for more mutual forbearance among its members than ours and—perhaps because of the field of observation being one that we cannot directly share with a colleague—none where the technique of exposition in our scientific discussions needs to be more carefully studied.

Earlier in this section of this paper Freud's analogy of a journey was referred to. We may return to that with the question whether there is any importance attaching to easy companionship in the journey of discovery? I think the answer varies greatly according to the temperament of the listener. Some people react against pleasure when learning from others, some require much of it.

Is the main thing during the meeting the experience of mutual discovery or a didactic attitude from speaker to audience? Or, if both are desirable upon occasion, how can they be

[4] Prof. Lionel Penrose, who kindly read the proofs, points out in respect to the Unwritten Agendas, that the total number of topics of discussion including the Written Agenda is two to the power *n*, where *n* is the number of Committee members who stay awake.

The practical importance of this formulation is that it gives a hint, perhaps a strong hint, that the enlargement of a small committee even by one member produces a greater effect than *arithmetical* proportions would suggest.

combined? When answering these questions —if indeed they are thought worthy of answer— we may perhaps bear in mind once again the extraordinary complexity of our subject matter and the peculiar, almost cloistered nature of our field of observation (the consulting room). Perhaps we can get furthest with these answers if, for a moment, we shift the whole discussion to a new direction, a consideration of the function of leadership in a scientific society.

A person who is given the privilege of reading a paper to be considered at a scientific meeting is undoubtedly accorded a leadership rôle. The way he uses the evening is dependent among other things on his notion of how that rôle should be fulfilled. There are conventions of different kinds which he can follow: (*a*) there are the derivatives of the 'Disputatio' of the Mediæval Schoolmen in which a proposition was put up and defended. Science owed much to this discipline for it gave precedence to intellectual clarity; but the combative atmosphere thus created tended to obscure the value of the less tough-minded persons whose gift lay more in seeing, perhaps at first dimly, the patterns of relationships which could not yet be codified by the constructs accepted by the Schoolmen. The 'Disputatio' finds among its modern descendants the ceremony of the M.D. Thesis in some of our ancient Universities and the 'reading-in' process (in lieu of examination) for full membership of our Society. The assumption underlying the 'Disputatio' is either that a student is fighting his way into a closed community or that he is fighting for a place for his ideas in an Established Body of Thought, i.e. that his ideas are Revolutionary. (This description of the 'Disputatio' refers to behaviour based on the Unwritten as well as the Written Agenda of the deliberation.) (*b*) There is an alternative assumption which may form the basis for a consideration of our problem. The model for this may be found in the 'Report on Work in Progress' given by one research worker to a meeting of the research team of which he is a member. Here the task of the group is to make an adjustment in the pattern of the hypotheses on which the research is based so that the findings outlined in the paper can be given their most effective place. This is best done if the underlying assumption is that all research workers are of equal competence (until the contrary be shown) and that no research worker can cover the whole field. The leadership rôle here shifts with each exposition of the problem, the evening's deliberation being centred more on the problem than the particular paper delivered to the gathering. But for the Research Conference meeting to be a success it is desirable that several persons should be prepared for the particular line of thought which the initial speaker will pursue, for in the measure of the importance of the idea presented so must the basis for it and its implications be thoroughly considered: the title of the paper is not enough to appraise the audience of the content.

It is beyond question that the former of these two methods increases the sense of importance of the reader of the paper and ministers to his narcissism and it is also beyond question that the latter involves more preliminary work both for the initial speaker and for the audience, and it is a fair guess that the latter in a scientific society is generally more profitable. The first speaker in a Research Conference has at least two things to prepare, first his written statement which would be circulated in advance, and then to prepare the short verbal statement in which he is addressing those persons actually present on that particular evening. The two statements would of course not be identical; the first should lead up to the second, which should point out particular problems and the attempted solutions. If the speaker lacks conceptual precision this soon becomes clear, in the procedure where the reader of a paper wearies his audience by reading verbatim from typescript his lack of conceptual precision is at times obscured by reason of the fatigue of his audience.

This leads to a further matter for our consideration, viz. the desirability of having more preparation for the evening discussions. When the emphasis is on A Person Reading His Paper a preliminary 'Working Party' is naturally almost an infringement of Prerogative Rights: but if the notion of a Research Conference is to be the basis of the evening's deliberation such preliminary work by a Working Party would be quite a natural thing. It would also help if such a Working Party were composed of persons with different views and willing to see the 'growing point' in research that goes on a different line from their own. The amount of time thus occupied in preparation for each meeting might at first seem to be a deterrent, but if our main consideration is the improvement of communication with one another the question of the best method of presentation must be faced.

Before we consider the methods of communication of psycho-analytical ideas to a psycho-analytical society it would perhaps be well to give a little thought to the classes or categories of ideas which may be communicated. These may at the moment be grouped under two headings: those which *alter the horizons* of our thoughts and those which *rearrange* (and thus clarify) the phenomena and the exposition of the theories which we deal with. The former are rare events even in the life of such a powerful and original thinker as Freud. The group of concepts contained in his *Interpretation of Dreams* is the best instance of ' horizon moving ' ideas, the concept of transference (Gestalt Closure in interpersonal relationships, it can be described—as can the second law of thermodynamics—in a number of ways), infantile sexuality, the structuring of the mental apparatus into Ego, Super-Ego and Id, and the concept of Quantity in psycho-dynamics (which includes the notion of force or urge both libidinal and destructive, Eros and Thanatos)—these great notions clear away confusions and bring about major syntheses. Without them the ' Rearranging ideas ' would not be effective. The whole of Freud's Theory of Neurosis is on this reckoning placed among the ' Rearranging ' series not in the ' Horizon Moving ' series; similarly his Group Psychology is derivative from his concept of Super-Ego functioning; Homeostasis, a concept which Freud imported into psychology with such great effect was originally a ' Horizon Moving ' idea, but in the field of psycho-dynamics it was a ' re-arranging ' one. The instance last given, if this classification may be reckoned useful at all, discloses a further problem: the idea came to Freud as a great revelation; he even noted the date and felt it to be an historical event (which indeed it was); the idea was transplanted and in its new site acquired a new strength. So we can add a third category, viz. ' Transplantations ', which are of course of great importance to the integration of the sciences. Those who like to employ a rather old-fashioned dichotomy would refer the ' Horizon moving ' ideas to the realm of the Pure and the ' Rearranging ' ideas to that of the Applied Sciences, but this should not be done in any spirit of depreciation of Applied Science as the instance given clearly shows.

These points are mentioned because of their application to a possible attitude to papers delivered to our Scientific Meetings: a ' Horizon Moving ' idea springs from the deeper levels of the mental experience of its author and is a tremendous event for him and for the world of science. Despite the excitement and often the depression which such an event causes in its creator, perhaps just because of the accompanying dismay at the magnitude of the consequences, a special clemency should be extended to him in the process of his expositions, which may spread over years. If one is watchful one notices that the new idea adds a burden to its creator as well as to the listener which is hard to endure, as well of course as providing a stimulus which makes the burden somewhat lighter. The travail produced by a new idea is easier if it is shared by an understanding audience, and the audience is usually more ready to accept it if its author can convey in his exposition something of the hesitation, even the feeling of modesty, which accompanies the act of creation. (The Latin tag given on the title-page of *The Interpretation of Dreams* if read in its context is felt as a *cri de cœur* as well as a challenge to high Heaven.)

The birth of such mighty ideas are occasions which do not lend themselves readily to the Working Party ' working-over ' to which reference has been made, for one reason that such ideas usually take years to assimilate; but all other ideas would in my view benefit from the method of Reporting on Work in Progress, and I think it is probable that the Scientific Meetings would be more profitable if the time was spent more than is now usually the case in discussing from many aspects the concepts which lead to, which relate to and which may be derived from the major topic of the evening.

Still using the now triple classification (' Horizon Moving ', ' Rearranging ' and ' Transplantation ') we may consider the relation of the Working Parties to ' Transplantation ' of ideas. The discussion of these relates usually to pure theory and are re-examinations of our everyday material in the light of concepts employed in other disciplines. The burden of new ideas here creates a slight sense of resentment at what seems at first viewing to be a needless importation—' we have got along without this notion, why bring it in at all, and besides it isn't " pure psycho-analysis ".' But, despite vexation, a new approach to familiar things, though the horizon is not altered, is often useful, not least because the philosophy of science is in constant process of change and our younger members are often more familiar with them than are their psycho-analytical teachers.

Working parties will lose much of their effectiveness if they do not span the generations. 'Transplantations' are more often done by the younger generation, who, after all, will in the next decades be the persons who will use them most. The pioneers of psycho-analysis were mostly young when they started analysis, and many of them stayed young in this sense till they died.

Ideas of 'Rearrangement' also lend themselves to Working Party treatment. This category includes the vast majority of the papers submitted to our societies. No horizon is altered, no concept is transplanted, but within the familiar field of action new applications are made of already known ideas, new data in support or modification of theory are disclosed and the general theories are given a closer link with observation. It is most useful, indeed quite indispensable, work in a growing science and is full of surprises.

It may be well to consider why the present, often somewhat inefficient and occasionally very tedious method of arranging our scientific meetings is adhered to, i.e. the verbal delivery of one-hour papers from typescript, when other ways of communicating ideas are within the experience of all members.

(1) Many people object to anything in the nature of organization, the idea of having a topic for the evening instead of a Member's Paper smacks of Planning and is thought to stifle spontaneity. With people whose work is as individual as is the analyst's this is understandable enough.

(2) A more serious objection is that the speaker is robbed of the opportunity of what I think may be called Surprise if he has been one of the initiators of a Working Party to prepare the topic of the evening. A paper is a sort of gift to colleagues and a gift loses some of its emotional quality if its specification is sent in advance. I think this factor of gift plays a considerable part in the Speaker-Audience relation in our meetings, and, despite disappointments, it is one which sustains a mode of organization which was more suited to small gatherings of a dozen or so than to the larger ones now assembling. It is pleasant to see a colleague on his feet meeting the challenge of the Society, this is particularly true of an Associate 'reading his Membership Paper' as it is called, but with the increase in numbers in a Society the opportunity to make a wide contact with colleagues in this way is reduced.

Related to the loss of Surprise there is a further objection to the Working Party idea and that is the risk, which some would feel more acutely than others, of having their ideas 'borrowed'. The value which persons place on having concepts attached to their name, or rather of having their name attached by colleagues to ideas, of course varies greatly, not only with the personalities of members, but with the morale in the Society as a whole. Here again the factor of number comes in, a uniformly high degree of sympathetic support for a partially formulated idea as the product and possession of a particular person is more likely to be found in a community numbering a dozen than in one of a hundred.

(3) The pride in originality and authorship is a human quality which has to be kept ever in mind in arranging the meetings, and though at times rigorous scientific pride may find itself alloyed with other sorts of pride this is a risk that must be taken by the Society. This is sometimes, but not always, related to another quality which may at first sight be thought to be threatened by the Working Party idea, *viz.*—

(4) The Leadership Rôle in delivering a paper to the Society. I do not believe the leadership function is closely connected with the delivery of papers as such, but rather with the support given to discussion in an intelligible and constructive way.

To conclude, I think the flow of ideas from one to another would proceed with greater ease and effectiveness if more attention was given to the way our meetings were arranged, to the factor of size (even of seating [5]) and the preliminary preparation of the papers either verbally or by prior circulation.

I recall that about fifteen to twenty years ago it was thought by some members to be an undesirable thing that there should be meetings of small groups of members to discuss topics which interested them since such private gatherings were likely to foster Cabals and to lessen attendance at and interest in the general meetings of the Society. Whatever may have been the reason in the past for deprecating such gatherings it is worth considering whether they should not be fostered now. Indeed such

[5] The arrangement of rows of seats all facing a rostrum does not facilitate the fluid development of discussion; the amphitheatre plan, where people can see nearly everyone else face to face, would seem more appropriate to the building up of ideas in a small community. But this is, of course, a matter of taste for no doubt some find an invigorating stimulus in the Lectern-and-Pew arrangement.

meetings have already begun: a meeting has already been held in London of Associate Members only; a move, surely, to be encouraged. There is one criterion for admission to any meeting of members and/or associates held in the premises of or under the auspices of the Institute which should in my opinion be insisted upon. Just as there is no justification for the expulsion of any member or associate on the ground of his holding any particular view as to the philosophy of science, medicine, psychology or even psycho-analysis, so it is my earnest hope that there will be no such grounds for the exclusion of any member and/or associate from any of the Discussion Groups that may be formed by or under the Institute. This is a negative criterion. The positive criteria in any Discussion Group that may be formed are, I suggest, for the Group itself to decide, and freedom should be given to such persons as desire to participate; they are particularly to be encouraged if they assist in the preparation for the scientific meetings and for the pages of the Journal. Indeed I look forward to the time when the first Wednesday in the month is given up to a full-scale meeting to give expression to the work of preparatory meetings (plural) held on a previous second Wednesday in the month. Again speaking personally I should be disappointed if in all of the preparatory meetings or any other ' Discussion Groups ' or ' Working Parties ' or whatever they may be called and held under the Institute all views were not well presented because parties with divergent views commonly have so much to give to each other and to the Society.

10. *On the Oral Tradition in Psycho-Analysis*

Some sciences deal with more or less isolated objects, and inspection of these, even the peering eyes of a host of observers, affect the phenomena not a whit. Comets do not blench at the staring multitude nor do animalculæ establish reciprocal relations with the biologist; but a psycho-analyst can hardly look at his patient without producing, though maybe but for a moment, a change. The psycho-analyst's material of observation and his mode of looking at it is, accordingly, a very subtle one, and it is therefore not surprising that though there are reams of description of case material and a lot of papers on technique the essence of the experience is more often than otherwise just not there. True the written descriptions give sections of the events observed which are of use to the psycho-pathologist, just as microscope slides are of use to the somato-pathologist; but slides alone do not give a clinical picture, nor do most of the descriptions of the interplay between analyst and analysand.

When we reflect on the source of our keenest understanding it will I think generally be found in the verbal instruction we have received from our great teachers. It may be well to consider this in some detail, for much depends on our preserving the oral tradition if we believe at all in its value.

An essential feature of oral communication in the sense here employed is that the speaker does *some* of his thinking while he speaks and that that thinking has reference to the actual audience before him. He does not give utterance in a universe of discourse to the whole world of science nor does he consider in the true humility of a teacher's love for his pupils that his dicta must and will stand the scrutiny of eternity: he speaks to those who are listening now and here before him, speaking to their groping need to understand the subtle experience he desires to communicate *to them* and listening himself to their response shapes his discourse to the uncovering of their understanding.

Whether the occasion be a seminar of students or a meeting of the Society in essentials it is the same. In the seminar the person at the moment speaking, ' who has the floor ' to use a parliamentary phrase, is given a leadership rôle whether he be teacher or taught; in the Society meeting the leadership rôle is emphasized by delivery from a rostrum, but, if the basic pattern of the discussion is that of reporting on research to a gathering of equals, the speaker will have in mind that his pleasure and his duty will lie in an encouragement of his hearers to clarify their own research ideas which may run on lines different but perhaps no less fruitful than his own: leadership in both cases wanders about the room as it were, no one holding it longer than is necessary for the exposition of his own notions or to lead the way to the elucidation of that of others.

To give free play to the process of thinking while speaking is difficult at any time and particularly so when the audience is not in complete sympathy with the speaker. It requires the compassion and imaginative gifts of the audience to be exercised with generosity to a considerable degree, and often an exercise in self-restraint, which is taken for granted in the

consulting room more often than in the meeting room. The fact is that the rostrum ministers to the speaker's egoism and when this governs his discourse or overrides his capacity for adaptation to his audience a counter-egoism is evoked in his hearers and a rhetorical dialectical struggle ensues. This spells death to an oral tradition, or rather to a consistently creative one.

To say that a person thinks while he speaks is not to deny him thought on the subject of his discourse before he speaks, but rather that since he has an audience now before him, a group of particular persons eager for his ideas, he must re-examine his subject *with* them, in their presence, so that they may be in a sense participant observers of the event in progress, viz. the elucidation of his thoughts. It must be acknowledged that the capacity to think, or re-think, spontaneously in this way is by no means uniformly distributed throughout the population, but it will be conceded that its occurrence is more frequent when the atmosphere is friendly, and of course in the assessment of the climate of opinion the speaker's projected hostility may exert a disturbing influence.

(The size of the audience plays a considerable part in the ease and the intimacy of oral communication. This is a strong reason for breaking up the gatherings of a large psycho-analytical society into small ' working parties ' which can combine their findings for reporting later on to the full assembly.)

It is only persons with a special gift for this kind of intimate verbal communication who can exercise it with force in the presence of a hundred persons. Though mechanical means may enlarge the range of the voice, no device is yet known which will bring a speaker as close to his audience as is social life across a dinner table. The physical distance between the speaker and listener is not the only factor, another is the ' accessibility ' of the speaker to his audience, perhaps the freedom with which he allows them in phantasy into the workshop or studio of his mind and his tact in removing their shyness when entering this territory.

Thus far when considering the oral tradition our attention has been turned to the preconditions for its occurrence, not for its content. If this could be defined I am sure that it would have been written down and published and thus would no longer be oral. Those who think that psycho-analysis is a science and only a science may comfort themselves with the belief that everything is in the literature; those who regard the practice of psycho-analysis as something of an art (as well as an employment of a scientific method) will have already learnt more from their teachers than their teachers knew they were giving. It is not a mere passing on of anecdotes about the great ones who are no longer with us, anecdotes have almost nothing to do with this transmission. Anyone will be able to give a final explanation of the Oral Tradition when he knows all there is to know about Cultural Transmission generally and Family Tradition in particular—the Oral Tradition in psycho-analysis comes somewhere between these two.

11. *A Personal Note about the Organisation of a Psycho-Analytical Society*

It is not practicable to give in an International Journal even an outline structure of a Scientific Society because local custom varies greatly from one country to another. But I think it would be desirable, perhaps in the form of a Preamble to the Byelaws, to include three maxims, which if followed might limit somewhat the tendency to woodenness found from time to time in Committees.

(1) Where there is any ambiguity in the wording of these Byelaws or other Regulations of this Institute, they shall be interpreted in the light of Common Sense.

(2) The Council, the Training Committee and any other Committee set up under these Byelaws will best serve the interests of Science and this Institute if, where there is a conflict between a new idea and an old custom they take a risk with the new idea rather than take shelter behind precedent, and where it is thought that the risk cannot be taken they put as much energy into a re-examination of present usage as went into the creation and exposition of the new and rejected idea.

(3) An Institution, even though its aim be the advancement of Science, has no intrinsic right to the expectation of a long life; it must every day earn the respect it receives and be content with less esteem than it deserves: to this general rule (which extends to the tenure of its Officers) this Institute is no exception.

If the term organization includes Officers and Committees, and their mode of election, tenure of office, etc., then the key to that structure in my view is given in Section 5 of this paper. I.e. the organization centres on the transmission

of knowledge and power to the next generation, and it does this by preparing that generation by giving it first the benefit of its own experience and then trusting itself to the increasing control of the younger generation. One of the dominant ideas in the mind of every Officer should be

TABLE SHOWING MEMBERSHIP
(MEDICAL AND LAY)

CONTINENT Location of Society	*Full Members* Medical+Lay=Total (1932) **1948**	*Associates* Medical+Lay=Total (1932) **1948**	*Total Full+Associates* Medical+Lay=Total (1932) **1948**
EUROPE Austria . .	(40) **7**+(10) **6**=(50) **13**	(11) **0**+ (3) **0**=(14) **0**	(51) **7**+(13) **6**=(64) **13**
Belgium .	(1) **2**+ (3) **3**= (4) **5**	Nil	(1) **2**+ (3) **3**= (4) **5**
Great Britain	(25) **38**+(17) **22**=(42) **60**	(20) **32**+(12) **13**=(32) **45**	(45) **70**+(29) **35**= (74)**105**
France . .	(13) **15**+ (2) **4**=(15) **19**	(9) **12**+ (4) **8**=(13) **20**	(22) **27**+ (6) **12**=(28) **39**
Holland .	(23) **29**+ (1) **1**=(24) **30**	(3) **5**+ (2) **2**= (5) **7**	(26) **34**+ (3) **3**=(29) **37**
Italy . .	(2) **2**+ (3) **5**= (5) **7**	(3) **5**+ (8) **10**=(11) **15**	(5) **7**+(11) **15**=(16) **22**
Sweden .	(5) **7**+ (0) **1**= (5) **8**	(3) **5**+ (0) **1**= (3) **6**	(8) **12**+ (0) **2**= (8) **14**
Switzerland .	(14) **14**+ (6) **7**=(20) **21**	(8) **8**+ (7) **9**=(15) **17**	(22) **22**+(13) **16**=(35) **38**
NORTH AMERICA Chicago .	(14) **49**+ (0) **3**=(14) **52**	(2) **0**+ (0) **4**= (2) **4**	(16) **49**+ (0) **7**=(16) **56**
Detroit . .	(0) **19**+ (0) **2**= (0) **21**	(0) **1**+nil=(0) **1**	(0) **22**+(0) **2**= (0) **22**
Los Angeles .	(0) **17**+ (0) **1**= (0) **18**	Nil	(0) **17**+ (0) **1**= (0) **18**

Note. The figures were taken from the printed lists of members published in this Journal vol. 1933 and 1948.

Certain countries have been omitted because of political reasons or because the Societies or Institutes in those countries are not sufficiently established for their numbers to be comparable.

that of Progressive Abdication to trained successors, of every Committee, in the words of Bacon: that ' It would be an unsound fancy and self-contradictory to expect that things which have never yet been done can be done except by means which have never yet been tried.'

AND ASSOCIATE MEMBERSHIP
IN 1933 AND 1948

CONTINENT Location of Society	*Full Members* Medical+Lay=Total (1932) **1948**	*Associates* Medical+Lay=Total (1932) **1948**	*Total Full+Associates* Medical+Lay=Total (1932) **1948**
New York .	(57)**124**+(1)**0**=(58)**124**	(4) **22**+ (3) **0**= (7) **22**	(61)**146**+(4) **0**=(65)**146**
Philadelphia .	(0) **12**+ (0) **1**= (0) **13**	(0) **5**+nil=(0) **5**	(0) **17**+ (0) **1**= (0) **18**
San Francisco	(0) **18**+ (0) **1**= (0) **19**	nil+ (0) **4**= (0) **4**	(0) **18**+ (0) **5**= (0) **23**
Association for Psycho-Anal. Medicine N.Y.C.	(0) **28**+nil=(0) **28**	(0) **6**+ (0) **1**= (0) **7**	(0) **34**+ (0) **1**= (0) **35**
Topeka, Kansas	(0) **16**+nil=(0) **16**	nil+ (0) **5**= (0) **5**	(0) **16**+ (0) **5**= (0) **21**
Washington, D.C. .	(20) **44**+nil=(20) **44**	(4) **0**+ (1) **0**= (5) **0**	(24) **44**+ (1) **0**=(25) **44**
SOUTH AMERICA Argentine .	(0) **7**+nil= (0) **7**	(0) **4**+ (0) **3**= (0) **7**	(0) **11**+ (0) **3**= (0) **14**
Rio de Janeiro	(0) **3**+nil=(0) **3**	Nil	(0) **3**+nil=(0) **3**
Sao Paulo .	(0) **4**+ (0) **2**= (0) **6**	(0) **1**+ (0) **1**= (0) **2**	(0) **5**+ (0) **3**= (0) **8**
ASIA India . .	(5) **4**+(10) **11**=(15) **15**	(2) **7**+(11) **29**=(13) **36**	(7) **11**+(21) **40**=(28) **51**
Israel . .	(0) **16**+ (0) **1**= (0) **17**	nil+ (0) **2**= (0) **2**	(0) **16**+ (0) **3**= (0) **19**

About fifty psycho-analysts reside in areas where there is now no organized society. The total number of psycho-analysts is therefore about 800.

(Received March 1, 1951)

DISCUSSION

DISCUSSION OF DR. K. R. EISSLER'S REMARKS ON THE PSYCHO-ANALYSIS OF SCHIZOPHRENIA[1]

DR. FRIEDA FROMM-REICHMANN: I feel sure that all psycho-analysts who work with schizophrenics are very grateful to Dr. Eissler for one of the central theses of his stimulating paper. I refer to his suggestion that when analysing a schizophrenic we differentiate sharply, for the purpose of evaluation of therapeutic results, between states of acute psychotic disturbance and 'mute' states, as he calls them. I agree with Dr. Eissler that almost every approach in which a psychiatrist makes use of his own 'primary processes' in order to address himself to the psychotic in terms of the patient's 'primary processes' may help the psychotic. This approach can be utilized by the psychotic to emerge, if and when the psychiatrist is able to convey to the patient that the doctor's complete concentration and intentness of purpose is directed toward helping him to recover. This may be done in terms of Rosen's method of 'direct interpretation' or of Eissler's own method of applying unconditional love, acceptance and care to his psychotic soldiers. This is also the case with my own former approach of unmitigated understanding and acceptance, which I described ten years ago in my paper on 'Transference Problems with Schizophrenics' (*Psychoanal. Quart.*, **8**, 1939), or in any similar way.

Emergence from the acute psychosis, however, has nothing to do with the *cure* of a schizophrenic. The contrary is true—another more serious problem begins with the patient's treatment in the post-psychotic state. We are particularly indebted to Dr. Eissler for having focused our attention upon this fact and for stating it definitely and clearly in so many words. Up to this point I am in agreement with Dr. Eissler. I have come to different conclusions, however, about the method of treatment that is the best approach to this symptomatological dichotomy. From our experience at Chestnut Lodge, it seems to me that throughout the whole course of his illness the schizophrenic can be treated with the same method. To express it in Federn's terms, a shift from the approach to the child in the schizophrenic during the disturbed period to the rationally guided analytic approach to the adult post-psychotic patient is hard for a schizophrenic to take. There is the danger of the patient's experiencing it as a severe rebuke. Also, the shift is difficult to accomplish for many psycho-analysts. For instance, Rosen, as we know, has reached the very legitimate conclusion that it is advisable (for him) to send his post-psychotic patients to another analyst for further treatment.

What, then, should a rationally guided psycho-analytic approach be like, which could be applied throughout the entire course of treatment? I agree with Eissler that it should not consist of interpretations of pregenital behaviour, nor any other content interpretation. In line with the general trend in psycho-analytic development, Hartman, Kris, and Loewenstein have demonstrated in their presentations at the 1950 meetings of the American Psycho-analytic Society, and in previous publications, that the most successful way of conducting psycho-analysis with *neurotics* is to focus central therapeutic attention on the analysis of the patient's *ego defences against facing his anxieties in his dealings with the psycho-analyst.* Prior to and concurrent with this development, H. S. Sullivan taught the use of the same approach in the analysis of what he called the 'security operations' of obsessional and schizophrenic patients with the analyst.

We have used this method with our schizophrenic patients for several years. I had the privilege of describing it in detail in a presentation at the 1948 meetings of the American Psychoanalytic Society. We have found that, if anything, it is even more important to use this method with schizophrenics than with neurotics. There are three reasons for this. First, the clarification of the real and the transferred elements of the doctor-patient relationship as one of the first interpersonal contacts of the emerging schizophrenic is of even greater therapeutic significance for the previously aloof and withdrawn schizophrenic than for the neurotic. Second, the schizophrenic's anxieties are more deeply rooted and more threatening than those of the neurotic, therefore his defences are more intense and intricate. Third, content-interpretation is indicated even less with schizophrenics than it is with neurotics because of the difference in the type of their dissociation and repression. The schizophrenic, more often than not, is aware of the content-meaning of his communications; however, he does need the analyst's help in order to understand the genetics and dynamics of his anxieties and of his defences against them. The psycho-analytic

[1] Presented at the Mid-winter Meeting of the American Psychoanalytic Association on December 8, 1950.

scrutiny of his security operations with the therapist seems to be the best way of doing this.

This being so, I do not feel *now* that the difference between the psycho-analysis of schizophrenics and of neurotics is as great as Dr. Eissler thinks. It is true that the psychological frame of reference in which schizophrenic thinking, feeling, and acting occurs, and consequently the means of communication in the analyst's exchange with the schizophrenic, are different from those of the neurotic. The flavour, the medium, and the type of the verbal exchange with the schizophrenic, therefore, differs from the psycho-analytic interchange with the neurotic. But there is no difference with regard to the basic direction of the treatment in both cases, which is the *psycho-analytic scrutiny of the defences against anxiety in the patient's relationship with the psycho-analyst.*

We apply this same approach also during the psychotic phases. It is true that frequently there will be no visible or audible response from the disturbed patient, but in most instances the analyst's approach registers. After their emergence, most of the patients refer to it, or follow the psycho-analyst if *he* does. Incidentally, we have found that as good a way to convey the doctor's intensive consistent concern for the patient as the various other ways which Dr. Eissler has enumerated is to see the psychotic through all phases of acute disturbance with the consistent attitude of a therapeutic investigator who time and again tries to engage the patient's interest in scrutinizing one and the same problem over and over again.

Now let me touch upon two points of minor importance in Dr. Eissler's interesting paper. Would it be more constructive and correct, perhaps, to consider the ' stubborn ' reactions of schizophrenics as negativistic ones? Are these patients afraid to give up their psychopathological manifestations in response to treatment, for fear of being overruled, effaced, or neglected? Is this negativism, then, their schizophrenic defence against this fear and anxiety?

In cases in which relapses and a return to previously relinquished symptoms are not caused by the schizophrenic's negativism, it seems to me that the same two sets of reasons may be found to be responsible as those which cause recurrences in the neurotic. Are they not either an expression of unclarified negative phases in the patient's relationship with the analyst, or the result of incomplete or faulty interpretations, or an indication of uncompleted working-through processes?

Let me mention the second point. It is true, I have found that schizophrenics may sense and react to hostile feelings which, unknown to the analyst, may be hidden behind his alleged friendly communications. Conversely, schizophrenics may clearly sense the analyst's friendliness hidden behind therapeutic responses which appear unfriendly, impatient, or antagonistic. Rather than these reactions being unwarranted, I have found in my experience and that of my associates that, as a rule, schizophrenics are correct in their emphatic evaluations of the analyst's unconscious motivations. This is one of the reasons many psychoanalysts are reluctant to undertake the taxing, but rewarding, analytic work with these patients. This is also one of the legitimate reasons for so much attention having been directed to the discussion of the personality of the analyst who works with schizophrenics. In Dr. Eissler's judgement, too much attention has centred here. In my opinion, the tremendous significance that the doctor-patient relationship assumes in the process of the interpersonal rehabilitation of the schizophrenic, and the many varying tests to which the patient submits the therapist, are further reasons for making the extensive discussion of the personality of the analyst an inevitable task as part of all discussions of psycho-analytic work with schizophrenics. This, of course, includes a serious investigation of all the analyst's actual and potential countertransference problems which should be repeated consistently throughout the course of the treatment.

Much more could be said in response to Dr. Eissler's interesting theoretical formulations. However, I have limited my discussion to the practical, therapeutic aspects of the paper, leaving the discussion of the more theoretical aspects to Dr. Wexler.

At present we at Chestnut Lodge are recording some of our work with schizophrenics, and thus hope to be able to soon follow Dr. Eissler's suggestion that full analytic treatment histories of schizophrenics be published as a basis for further discussions of their psycho-analytic treatment.

MILTON WEXLER, Ph.D.: It has been a very rewarding experience to read and to think about Dr. Eissler's contribution. He brings into focus some of the most crucial issues in relation to the psycho-analytic therapy of schizophrenia. In my estimation such problems as are inherent in the functions of interpretations, communication via the primary processes, the use of love and aggression as technical manœuvres, and the rôle of the superego in relation to delusions and reality appraisal, should be nuclear to our research interests.

It is my impression that the centre of gravity in Dr. Eissler's paper can be found in his observation that the schizophrenic patient in the acute phase can be approached with maximum affection or with that maximum of aggression which he can tolerate. Dr. Eissler likens this to Ferenczi's division of hypnotic techniques into paternal and maternal behaviour. Had Dr. Eissler really acknowledged this as the focal point in his discussion, I believe his theoretical and technical inferences would have had somewhat greater clarity and perhaps a broader scope. I would like to examine his observations with this in mind.

Quite clearly Dr. Eissler considers his treatment of the Army casualties as representative of the maternal approach, employing a maximum of loving emotionality, fascinated attention, and an enthusiastic, optimistic attitude that the patients would get well. The whole situation was charged with affective interchanges, which Dr. Eissler equates with intercommunication via the primary processes.

When, at a later point, Dr. Eissler refers to his so-called ' aggressive ' and paternalistic behaviour towards a female patient whose money he took and counted, considerable doubt seems to assail him; and this despite the fact that the patient attributed her relief to the doctor's forceful and decisive action. Suddenly Dr. Eissler is driven to ask himself if this was not merely a masochistic gratification for the patient, even though Sechehaye's idea of satisfying every need actually or symbolically had previously had some appeal for Dr. Eissler. He even attributes an extraordinary potency to his behaviour and suggests that this small act of counting the patient's money may have fixated the patient in subsequent repetitive demands for masochistic gratification, all to the great damage of the analytic treatment in the ' mute ' phase.

I will not quibble about whether Dr. Eissler was really aggressive in his action. It seems, however, that he believes that father's behaviour is surrounded with imminent and potent danger, while mother can do no wrong. Why does he not question whether spoon-feeding his soldiers and bathing them in loving affection could not either provoke homosexual panics or fixate these patients in dependent sucking attitudes to the great detriment of subsequent analytic treatment?

I even wonder why Dr. Eissler omitted to take into consideration his own most sensitive observations concerning the therapy of Gertrud Schwing, observations he made in a much earlier paper. There he remarked that Schwing's loving touch was probably so effective because she worked in a hospital where cruelty and discipline were the keystone approaches of the medical and nursing staffs. But he does not list among the special considerations applicable to his schizophrenic soldiers that they received his loving care against the backdrop of discipline and indifference in the military encampment from which they had so recently come. I say these things in order to urge two points: First, that there is no special virtue to be attached to our maternalism and no special fear to be attached to our paternalism. Secondly, that these are not either/or alternatives in technique, but that both are applicable by the same therapist to the same patient, dependent on dynamic, economic and structural circumstances which must be accurately assessed by the analyst.

Precisely these same considerations should have led Dr. Eissler to make an important extension of his remarks on the rôle of the superego. I believe his comments on the function of the superego in sanctioning and entrenching the reality quality of schizophrenic delusions to be an excellent contribution. But at no point is a link specifically made with his central problem of technique, a surprising omission since, in quite another context, Dr. Eissler makes the very pertinent observation that the Church, Christ, and the Gospels seem to have had a quite powerful curative effect on schizophrenics. This omission is quite in keeping with, on the one hand, Dr. Eissler's courage and unconventionality in recommending an omnipotent attitude in the therapist, and then, on the other, ruminating about the possible effects of what he calls aggression in counting the money of a masochistically inclined patient.

The issue will come into sharper relief if we consider that Dr. Eissler confines his discussion of communication via the primary processes to those circumstances with his soldiers when he and his assistants spoke the language of affectionate maternal love. On this basis why is it not also communication via the primary processes to speak in the language of the schizophrenic's archaic superego, to ally oneself with this primitive, conscience-ridden structure, and to establish contact on this basis? It is certainly my impression that, as Dr. Eissler defines it, the assumption of superego rôles by the therapist is also a kind of communication employing the primary processes. More than that, it is a communication in terms of the psychic instance which Dr. Eissler assumes to be responsible for imposing or consenting to the delusional system, thereby giving it the value of reality. In brief, it is essentially a way of participating in and identifying with the schizophrenic's reality.

Seen in this perspective I believe that Dr. Eissler's contribution achieves a much larger significance. It is possible to understand that our affectionate emotional approaches may serve as effective communication up to the point where the seductive aspects of such tenderness threaten the patient with altogether too disruptive emotions. Restrictive, prohibitive, conscientious, and even omnipotent superego rôles may also be appropriate, not only in stemming the tide of overwhelming instinctual eruptions, but also in establishing direct and effective communication with the patient's psychotic perspectives. In either case the therapist speaks what Dr. Eissler refers to rather loosely as the language of the primary processes. In accepting the possibility of both types of behaviour by the therapist for dealing with any single patient we extend the range and flexibility of our therapeutic behaviour to meet the shifting economic and dynamic situation of the psychosis.

I have chosen to omit the discussion of many important aspects of Dr. Eissler's paper in order to consider the broad outlines of one central issue. I would like now to put a question to him which deals not so much with what he has presented us

with to-day, but rather with a problem which is implicit in his presentation and, as I see it, represents the next logical preoccupation for his theoretical formulations.

Granted that communication via the primary processes serves to establish contact with the patient; granted that such contact leads to a redirection of narcissistic libido toward external objects; by what psychic processes, by what new structural, dynamic or economic circumstances do some schizophrenic patients manage to survive a separation from the therapist without collapse of the renewed object cathexis, and without immediate abandonment of the newly-won world of reality? Simple descriptive answers, of the kind suggested by Dr. Eissler, such as the spreading of libidinal and aggressive cathexes to other objects, will not do.

My admiration for the contribution Dr. Eissler has made to-day leads me to hope he will apply himself next to this question, and offer us some answers as challenging and fruitful as his present remarks on the psycho-analysis of schizophrenia.

CLINICAL ESSAY PRIZE

Members and Associate Members of the International Psycho-Analytical Association are reminded that competitors for the Clinical Essay Prize must send in their work to the Hon. Secretary of the Institute of Psycho-Analysis, 96 Gloucester Place, London, W.1, by March 31 of the year in which they wish to enter into the competition.

The conditions governing the competition are the following:—

A prize of (not exceeding) 30 guineas is offered.

Requirements for the Essay

The essay shall consist of a clinical record of a case investigated by psycho-analytical methods. It should illustrate clearly the events and changes in the mental life of the patient and their relation to external environment. In awarding the prize, the Judges will pay attention to acuity of observation and the clarity with which the facts are stated. If the writer wishes to draw theoretical conclusions, he must bear in mind the necessity of making the evidence for such conclusions carry conviction.

It is recommended that the length of the essay should not exceed twenty thousand words.

Date of Sending in Essays : Language : Format, etc.

Essays must be submitted on or before the thirty-first day of March in any year, in the English language. They must be typescript on quarto paper with ample left-hand margin. They must be in triplicate and be sent to the Hon. Secretary of the Institute. All copies of essays submitted become *ipso facto* the property of the Institute (or its successor) while it has the appointment of the Trustees for the Prize Fund.

No Award

If no essay of merit worthy of a prize is submitted in any year, no award shall be made for that year.

Joint Award

In the event of the Judges regarding the essays of two or more competitors of equal merit, they may divide the prize-money into equal parts and award it to such competitors jointly.

Eligibility

Any person of either sex, who is not a member or a past-member of the Board of the Institute, shall be eligible for the competition.

Tenure

The prize shall be given to the writer of the best essay in the opinion of the Judges submitted in any year, but the prize may be awarded to the same person twice, provided that he submits a second essay of sufficient merit in a later competition, and that the prize shall not be awarded more than twice to the same person.

Title

The competitor to whom the prize is awarded in any year may be called the Clinical Prizeman for that year.

Copyright

The copyright of any essay to which a prize is awarded shall become the property of the Institute. Should the author wish to quote it in whole or in part, the Institute shall not unreasonably withhold its consent. The Institute shall not publish in England or abroad, whether in English or in translation, the whole or any part of such essay during the author's life-time without his consent in writing. Other persons who may wish to quote extracts from any prize essay shall obtain the written consent both of the Institute or its successors, and, during his life-time, of the author.

MARGARET LITTLE

Hon. Secretary,
Institute of Psycho-Analysis,
96 Gloucester Place,
London, W.1.

OBITUARY

PAUL FEDERN

Dr. Paul Federn was one of those individuals possessing a rare combination of qualities and personal characteristics that make it possible to at once be a good father and family man, a warm and intimate friend, a humanitarian, a teacher, and a true scientist. My acquaintance with Dr. Federn spanned a period of forty-two years from the time I first met him in 1908 until the time of his death in 1950. During this period I had the opportunity to work with him as student and as colleague, and I came to realize how rare a personality he was.

In his early years he was strongly influenced by the personality of his father, Solomon Federn, a distinguished Viennese physician. It was his father who did pioneer work in the field of measurement of blood pressure and who was jokingly referred to as 'Blutdruck Federn'. This same spirit of pioneering and of original creative work in new fields of science is apparent in the specific contributions of Paul Federn in his studies on psychosis and in his significant development of new and challenging concepts in the field of ego psychology.

He was a devoted husband and father. His wife was a former patient of his from his days as a general physician before he had developed an interest in analysis. Theirs was a very happy marriage; a close and warm relationship which lasted until her death shortly after his first operation. Knowing as he did that she was chronically ill, her death still came as a profound shock to him. He survived her by less than half a year. Only those close to Dr. Federn knew how deeply grieved he was when one of his sons was a prisoner in Nazi concentration camps, at Dachau and Buchenwald, and how correspondingly great was his happiness on learning of this son's ultimate release and safety.

He knew his moments of relaxation, too. There was always his favourite game of Tarok, which was also the favourite entertainment of Freud. The afternoons and evenings during which the game was played at his home were great sources of pleasure to himself and his close friends. Even in these games his participation was characterized by the same persistence and singleness of thought which were typical of him in his scientific work.

I vividly remember my impression of him when I began to work intensively with him in 1909: a bald, slender man with a full, black beard and dark, expressive eyes, and yet one extremely mild in manner and expression. At that time I was deeply impressed with his sensitivity to the needs and feelings of his patients and with his unusual ability to create within the patient the feeling that he was being understood. One could not but be aware of the breadth of the scientific and literary background that he brought to bear in his work with his analysands. He had the extraordinary talent of being able to illustrate a significant point in analysis by quoting passages from the great poets and writers which would really throw light on the particular problem that the individual was working through.

His very deep and sincere interest in his patients was even more evident after he learned that he had to undergo a second operation which he knew would be doomed to failure. In addition to taking care of all of his personal affairs to the most minute detail, he arranged for his patients to be transferred to other psychotherapists, choosing with care the therapist that he felt would be of most help to each patient. Even after he became aware of the nature of his illness and recognized how limited his financial resources were, he still persisted in taking on some patients free of charge, as had been his practice all through his life. Many times he expressed to his family and friends his feeling that he could see no reason for living beyond the point where he could be of help to others.

The feelings of social responsibility which he developed in his father's home were influential in directing his activities in fields other than that of psycho-analysis. He did not limit himself to the problems of humanity as they were revealed on the analyst's couch. He

participated actively in movements designed to set up better standards of medical and social welfare in such fields as sex education and maternal health. He worked actively with his sister in founding one of the first settlements in Vienna, and for some time worked as physician in this settlement. He was also a prominent member of the Social Democratic Party of Vienna and served as a city councillor, giving much effort and energy to the establishing of mental hygiene clinics in that city.

In his rôle as teacher he was most skilful in developing in his students an appreciation for and understanding of technical and intricate psychological problems. It is to his credit that this was never done at the expense of watering down and oversimplifying the material, but rather by high ability to translate the difficult and obscure into meaningful terms.

But his teaching went far beyond that of the individual teacher-student relation. He was interested in orienting all possible groups of people in educational and sexual problems and measures for mental prophylaxis, and he devoted many papers to problems concerning mental hygiene, sociology, pedagogy, and family guidance. A close friend of Professor Dr. Heinrich Meng, he edited, in collaboration with him, *Das Arztlich Volksbuch*—' The People's Medical Book '— and *Das Psychoanalytische Volksbuch* —' The People's Book of Psycho-Analysis '. These volumes were intended not only for physicians, but for all educated persons interested in mental hygiene, emotional disturbances, and social problems.

Federn's scientific productivity spanned the whole of his professional life. His work in the field of psycho-analysis dates back to 1901, when he first joined Freud in the psychoanalytic movement.

In all his utterances and writings Federn's absolute loyalty to Freud was apparent. He admired Freud as a man and as a scientist, and considered him an outstanding genius of all time. He was fascinated by Freud's writings, took great pains in interpreting correctly their every phrase, and was embittered by their critics. His admiration for Freud did not hinder him from going his own way in his investigations, or from revealing in his own concepts his great originality of mind. He liked, however, to consider his findings as only confirmations and elaborations of Freud's basic dynamic concepts. Only hesitantly, and after lengthy discussion, did he admit some discrepancies between his and Freud's theories concerning the dynamic structure of the ego.

Federn's ability to deal with the significant aspects of problems and to get at the heart of an issue under discussion were apparent already in the early days before World War I at the meetings of the Vienna Psycho-Analytic Society. I often sat with him at the meetings. During those days every session was attended by Freud. Among others present were Sadger, Tausk, Steiner, Nepalek, Silberer, Reitler, Dattner, Friedjung, Rank, Sachs, and occasionally Ferenczi and Jones. Dr. Federn's remarks at these meetings were always acute and appropriate.

It should be noted that in his approach to the problem of mental disease he did not limit himself to the theories and techniques of psycho-analysis. A bare few weeks before his death he was still actively interested in studies from other disciplines that might throw light on the problems of emotional disorders. Despite his own training and the investment of his efforts largely in the area of psycho-analysis, he felt that we should not be blind to the avenues of study that might help to explain mental illness in physiological and chemical terms.

Though his greatest contributions to psychoanalysis lie in the field of the psychology of the ego, mention should be made of his other important contributions.

In 1913 he published ' A Case of Nocturnal Fright, with Subjective Light Phenomena ', and from that time on he revealed his psychoanalytic talent, psychological understanding, and scientific originality in many papers. Some of his findings in ' Sources of Male Sadism ', in ' Some General Remarks on the Principles of Pain-Pleasure and Reality ', and in ' Contributions to the Analysis of Sadism and Masochism ', were cited by Freud. In ' A History of a Case of Melancholia ', he clearly illustrated the pathogenic process which Freud found typical for melancholia, namely, the patient's identification with an ambivalently loved object.

In 1919 Federn published a pamphlet, *Die Vaterlose Gesellschaft*, which might be translated as ' The Orphaned Nation: An Essay on the Psychology of Revolution '. Although this fascinating study was based on the concepts that Freud had expressed in *Totem and Taboo*, Federn's ideas about the function of the leader in socio-psychological organizations and the development of a democratic brotherly society appeared before and were precursory to

Freud's expositions on ' Group Psychology and Ego Analysis '.

Federn's studies and contributions to ego psychology will ultimately have significant implications in psycho-analysis both in terms of theory and in terms of technique of therapy, particularly for the psychotic. His main concept is that the ego as an experience is a reality. It is not a mental abstraction, not the sum of separate functions; it is something which each individual feels. Federn's investigation rests on introspective description of his own self, of other persons, healthy and diseased. His theory stems from an accurate phenomenological description of the ego which is an *Erlebnis*. This experience is a coherent unity which undergoes changes that Federn called ' ego states '. From his phenomenological description he formulated his theories. To account for the dynamic aspects of the ego he postulated a proper ego cathexis with flexible boundaries.

Several implications of his ego concept are significant. One is the study of the sense of reality, which has to be distinguished from reality testing. The stimuli which impinge on the ego boundary from without are experienced as external reality, and mental elements which participate in the ego unity are felt as mental and not real. His theory offers an explanation of hallucinations and delusions. Another is that the psychoses, especially schizophrenia, are due to a diminution rather than an increase of ego libido. From these implications derive new directions for the therapy of psychoses which is different from that of neuroses.

It is impossible to deal adequately with the full significance of Federn's ego theory in a brief paper of this kind. Suffice it to say that Federn himself recognized this as his most important work. When I last saw him at Christmastime, 1949, he knew that he would soon die. He said to me, ' Don't grieve when I am gone, for I have already written what I had to say in the field of ego psychology '. He felt his task to be completed. In his evaluation of his own work, as in so many of his other evaluations, he was right. When those of us who knew him personally and, therefore, feel his loss more keenly are no longer here, his work will still serve as a path leading to further study for younger analysts who may follow in his footsteps. That will be his truest memorial.

Edoardo Weiss.

BIBLIOGRAPHY OF THE WRITINGS BY DR. PAUL FEDERN [1]

1901 ' Zur Reform des ärztlichen Spitalsdienstes ', *Wiener klinische Rundschau*, **15**, 276–278, 293–294.

1912 Contribution to: *Die Onanie*. Vierzehn Beiträge zu einer Diskussion der ' Wiener Psychoanalytischen Vereinigung '. (Verlag Bergmann, Wiesbaden), pp. 68–82.

1913 ' Ein Fall von Pavor nocturnus mit subjektiven Lichterscheinungen ', *Z.*, **1**, 556–559.

1913 Rev. of: Trigant Burrow, ' Freud's Psychology in its Relation to the Neuroses, (*Amer. J. med. Sci.*, June, 1911); ' Some Psychological Phases of Medicine, (*J. Abnormal Psychology*, August–September, 1911), *Z.*, **1**, 181–182.

1913 Rev. of: Ernest Jones, *Der Alptraum in seiner Beziehung zu gewissen Formen des mittelalterlichen Aberglaubens* (Leipzig-Wien, 1912), *Z.*, **1**, 497–500.

1913 ' Beiträge zur Analyse des Sadismus und Masochismus. I. Die Quellen des männlichen Sadismus ', *Z.*, **1**, 29–49.

1914 ' Beiträge zur Analyse des Sadismus und Masochismus. II. Die libidinösen Quellen des Masochismus ', *Z.*, **2**, 105–130.

1914 ' Über zwei typische Traumsensationen. 1. Vorbemerkung. 2. Über den Hemmungstraum. 3. Über den Flugtraum ', *Jb.*, **6**, 89–134.

1914 ' The Infantile Roots of Masochism ', *N. Y. Med. J.*, **100**, 351–355. (Abstract and Discussion: *J. Nerv. Ment. Dis.*, **41**, 596–599; *Med. Rec.*, N. Y., **86**, 822–824.)

1914 ' Lust-Unlustprinzip und Realitätsprinzip ', *Z.*, **2**, 492–505.

1915 ' Some General Remarks on the Principles of Pain-Pleasure and of Reality ', *R.*, **2**, 1–11.

1919 ' Zur Psychologie der Revolution ', *Der Österreichische Volkswirt*, **11**, 571–574, 595–598.

1919 *Zur Psychologie der Revolution: Die Vaterlose Gesellschaft*. 29 pp. (Wien: Anzengruber-Verlag.)

1919 ' Einschlafen und Einschläfern ', *Wien. klin. Wschr.*, **32**, 1243–1244.

1919 Rev. of: Max Marcuse, *Wandlungen des Fortpflanzungsgedankens und Willens* (Bonn, 1918–19), *Z.*, **5**, 218–220.

[1] Abbreviations: *Z.—Internationale Zeitschrift für Psychoanalyse.*
I.—Imago, Zeitschrift für psychoanalytische Psychologie ihre Grenzgebiete und Onwendunyen.
Z. f. ps. Päd.—Zeitschrift für psychoanalytische Pädagogik.
Alm.—Almanach der Psychoanalyse.
R.—Psychoanalytic Review.
J.—Int. J. Psycho-Anal.

1919 Rev. of: Alfred Adler, *Das Problem der Homosexualität* (München, 1917), *Z.*, **5,** 220–221.

1919 Rev. of: Karl Frank, *Die Parteilichkeit des Volks- und Rasse-Abergläubischen* (Wien, 1919), *Z.*, **5,** 221–222.

1920 ' Zur Frage des Hemmungstraumes ', *Z.*, **6,** 73–75.

1920 Rev. of: Bernhard Aschner, *Die Blutdrüsenerkrankungen des Weibes* (Wiesbaden, 1915), *Z.*, **6,** 89–90.

1920 Rev. of: Emil Lorenz, *Zur Psychologie der Politik. Über Erziehung und Bildung* (Klagenfurt, 1919), *I.*, **6,** 94.

1921 Rev. of: Th. Zell, *Die Diktatur der Liebe* (Hamburg-Berlin, 1919), *Z.*, **7,** 88–91.

1921 Rev. of: Ulrich Grüninger, *Zum Problem der Affektverschiebung* (Zürich, 1917), *Z.*, **7,** 497–500.

1922 Rev. of: Albert Moll, *Behandlung der Homosexualität: biochemisch oder psychisch?* (Bonn, 1921), *Z.*, **8,** 84–86.

1922 Rev. of: Paul Krische, *Marx und Freud. Neue Wege in der Weltanschauung und Ethik des Freidenkers* (Berlin, 1922), *I.*, **8,** 512.

1923 ' Die Geschichte einer Melancholie ', *Z.*, **9,** 201–206.

1923 Rev. of: Arthur Kronfeld, *Über Gleichgeschlechtlichkeit. (Erklärungswege und Wesensschau)* (Stuttgart, 1922), *Z.*, **9,** 96–97.

1923 Rev. of: Van Deshook und Stekel, ' Die psychische Behandlung des Tic ' (in: *Die Therapie der Gegenwart*, **63** (24) (1922)), *Z.*, **9,** 224.

1923 Rev. of: Hans Blüher, *Secessio Judaica* (Berlin, 1922), *I.*, **9,** 138–139.

1924 ' Varendonck ', *Z.*, **10,** 203–204.

1924 Rev. of: Max Schwab, ' Die Ursache des unstillbaren Erbrechens (*Zbl. Gynäk.*, **45,** H. 27 u. 42, 1921), *Z.*, **10,** 331.

1924 Rev. of: W. Jacobi, ' Über die Bedeutung extrem eingestellter psychologischer Forschungsrichtung in der Psychiatrie (*Med. Klinik*, **18,** H. 42), *Z.*, **10,** 477–478; (1925) *I.*, **11,** 187.

1924 ' Masturbation ', *Journal of Sexology and Psychoanalysis*, **2,** 251–266.

1924 Rev. of: Gustav Le Bon, *Psychologische Grundgesetze in der Völkerentwicklung* (Leipzig, 1922), *I.*, **10,** 352–353.

1925 Rev. of: Hans Driesch, ' Bewusstsein und Unterbewusstsein ' (*Dtsch. med. Wschr.*, **48,** H. 37 (1922)), *I.*, **11,** 185–186.

1926 ' Einige Variationen des Ichgefühls ', *Z.*, **12,** 263–274.

1926 ' Some Variations in Ego-Feeling ', *J.*, **7,** 434–444.

1926 ' Freud'sche Psychotherapie ', *Deutsche Zeitschr. f. Homöopathie*, **5,** 546 *ff.*

1926 ' Ein Colloquium über Freud'sche Psychoanalyse ', *Allgemeine homöopathische Zeitung*, **174,** 218.

1926 ' La signifio de psiĥoanalizo por la curacisto' , *Internacia medicina revuo*, **4,** 115–119.

1926 Contributions to: *Das Psychoanalytische Volksbuch.* Edited by Paul Federn and Heinrich Meng. (1st ed. 1926, 2nd ed. 1928, 3rd ed. 1939, Ital. ed. 1949.) ' Stellung der Psychoanalyse zur übrigen Psychotherapie ', ' Die psychoanalytische Heilmethode ', ' Schutz vor Nerven- und Geisteskrankheiten ', ' Körperliche Hygiene des Geschlechtslebens ', ' Seelische Hygiene des Geschlechtslebens ', ' Hysterie und ihre Behandlung' , ' Funktionelle Störungen des Geschlechtsaktes ' (with H. Meng), ' Psychoanalyse und Medizin ', ' Märchen—Mythus—Urgeschichte ', ' Über einige Fortschritte der psychoanalytischen Forschung ' (with E. Weiss) (1939).

1926 (1924) Contributions to: *Das Arztiche Volksbuch.* Edited by H. Meng. Three editions (Stuttgart, 1924–29). ' Der Arzt im Dienste der Gesundheitspflege.' (Others are incorporated in the *Psychoanal. Volksbuch.*)

1927 ' Zur seelischen Hygiene des Geschlechtslebens ', *Die Neue Generation*, **23,** 1–9.

1927 ' Narzissmus im Ichgefüge ', *Z.*, **13,** 420–438.

1928 ' Narcissism in the Structure of the Egó ', *J.*, **9,** 401–419.

1927 ' Die Wiener Diskussion [über Onanie] aus dem Jahre 1912 ', *Z. f. ps. Päd.*, **2,** 106–112.

1928 *Psychoanalyse: Reclam. Praktisches Wissen.* 3. erw. Aufl. (Leipzig, 1928).

1929 ' Über einen alltäglichen Zwang ', *Z.*, **15,** 214–221.

1929 ' An Every-Day Compulsion ', *J.*, **10,** 130–138.

1929 ' Das Ich als Subjekt und Objekt im Narzissmus ', *Z.*, **15,** 393–425.

1929 ' Die Diskussion über " Selbstmord ", insbesondere " Schülerselbstmord ", im Wiener Psychoanalytischen Verein im Jahre 1918 ', *Z. f. ps. Päd.*, **3,** 333–344.

1929 ' Selbstmordprophylaxe in der Analyse ', *Z. f. ps. Päd.*, **3,** 379–389.

1930 ' Der neurotische Stil ', *Abhandl. a. d. Neurologie, Psychiatrie, Psychologie u. ihren Grenzgebieten*, H. **61,** 194–201. (Reprinted in *Alm.* (1932), 15–26.)

1930 ' Psychoanalytische Auffassung der " intellektuellen Hemmung " ', *Z. f. ps. Päd.*, **4,** 393–408.

1930 ' Neurasthenic Core of Hysteria ', *Med. Rev. Reviews*, **36,** 140–147.

1930 ' Psychoanalytical Method of Treatment ', *Med. Rev. Reviews*, **36,** 421–433.

1930 ' Die Wirklichkeit des Todestriebes. Zu Freuds " Unbehagen in der Kultur " ', *Hippokrates*, **3,** 341–366. (Reprinted in *Alm.* (1931), 68–97).

1932 ' The Reality of the Death Instinct, Especially in Melancholia. Remarks on Freud's Book,

Civilization and its Discontents', *R.*, **19,** 129–151.

1931 'Zum 6 Mai 1931', *Z. f. ps. Päd.*, **5,** 233–240.

1931 'Über die Wirkung sexueller Kräfte in der Seele', *Sexualnot und Sexualreform* . Verh. d. IV. Kongr. d. Weltliga f. Sexualreform, pp. 123–134.

1931 'Eduard Hitschmann zum 60 Geburtstag (28 Juli 1931)', *Z.*, **17,** 420–423.

1932 'Sixtieth Birthday of Edward Hitschmann (July 28, 1931)', *Int. J. Psycho-Anal.*, **13,** 261–264.

1931 'Vom Nationalgefühl', *Alm.* (1931), 97–101.

1931 'Der Lebensmüde im Krankenhaus', *Österreichische Blätter für Krankenpflege und Fürsorge*, **7,** 77–86.

1932 'Weariness of Life in Hospital Patients', *Mental Hygiene*, **16,** 636–649.

1931 *Psychologie der Familienfürsorge.* Jahresbericht des Wiener Settlement.

1931(?) *Psychology of Family Guidance.* American Annual Book for Settlement Work.

1932 'Das Ichgefühl im Traume', *Z.*, **18,** 145–170. (Reprinted in *Alm.* (1933), 96–130.)

1932 'Ego Feeling in Dreams', *Ps. Quarterly*, **1,** 511–542.

1933 'Die Psychosenanalyse. Zur Indikation', *Z.*, **19,** 207–210.
'Die Psychosen-Analyse. Zur Technik', *Z.*, **19,** 444–449.

1934 'The Analysis of Psychotics. On Technique', *J.*, **15,** 209–214.

1933 'Sandor Ferenczi', *Z.*, **19,** 305–321.

1933 'Sandor Ferenczi', *J.*, **14,** 467–485.

1933 'Die vier Frongesetze der Zwangsneurose', *Z.*, **19,** 616–620.

1933 'Die Ichbesetzung bei den Fehlleistungen', *I.*, **19,** 312–338, 433–453.

1933 'Zunahme der Süchtigkeit', *Die Bereitschaft*, **13,** 77–79. (Reprinted in *Alm.* (1935),54–60.)

1933 'Zunahme der Süchtigkeit', *Sozialärztliche Rundschau.*

1933 'Zirkuläre Freundschaftsbeziehungen', *Wiener med. Wschr.* **83,** 470–472.

1933 'Relazioni cicliche di amicizia', *Riv. ital. Psicoanal.*, **2,** 173–178.

1933 'Frigidität', *Wien. klin. Wschr.*, **46,** 671.

1933 'Verhalten des Hausarztes gegenüber den Neurosen', *Wien. klin. Wschr.*, **46,** 1462–1463.

1933 'Nachbarhilfe für Arbeitslose', *Blätter f. d. Wohlfahrtswesen d. Stadt Wien*, **32,** 21–23, 41–43, 49–51.

1934 'Das Erwachen des Ichs im Traume. I. Die Orthriogenese. II. Thesen zur Ich-Psychologie', *Z.*, **20,** 109–112.

1934 'The Awakening of the Ego in Dreams. I. Orthriogenesis. II. Postulates to Serve as a Basis for an Ego Psychology', *J.*, **15,** 296–301.

1934 Rev. of: Adolf Basler, *Über die Anpassung des Organismus an die Umwelt* (Canton-Leipzig, 1933), *I.*, **20,** 252–253.

1934 'Mental Factors in the World Depression', *J. Nerv. Ment. Dis.*, **79,** 43–58.

1935 Rev. of: Vera Dantschakoff, *Les Bases de la Sexualité* (Paris, 1934), *Z.*, **21,** 104–105.

1936 'Zur Unterscheidung des gesunden und krankhaften Narzissmus', *I.*, **22,** 5–39. (Partly reprinted in *Alm.* (1937) as 'Ichgrenzen, Ichstärke und Identifizierung'.)

1936 Rev. of: R. G. Hoskins, *Die Hormone* (Leipzig, 1934), *Z.*, **22,** 409–410.

1937 'Die leitungslose Funktion im Zentralnervensystem. Eine Frage der Psychologie an die Physiologie', *Z.*, **23,** 250–274.

1937 Rev. of: G. Parcheminey, *Le Problème de l'Hystérie* (Paris, 1935), *Z.*, **23,** 323–325.

1938 'The Undirected Function in the Central Nervous System. A Question Put to Physiology by Psychology', *J.*, **19,** 173–198.

1940 'Hysterie und Zwang in der Neurosenwahl', *Z. and I.*, **25,** 245–263.

1940 'The Determination of Hysteria *Versus* Obsessional Neurosis', *R.*, **27,** 265–276.

1940 'Psychoanalysis as a Therapy of Society', *Amer. Imago*, **1,** 65–80.

1942 'Some Suggestions on the Mental Hygiene of Soldiers', *Mental Hygiene*, **26,** 554–559.

1943 'Psychoanalysis of Psychoses. I. Errors and how to avoid them. II. Transference. III. The Psychoanalytic Process', *The Psychiatric Quarterly*, **17,** 3–19, 246–257, 470–487.

1944 'A Dream under General Anaesthesia. Studies in Ego-Cathexis', *The Psychiatric Quarterly*, **18,** 422–435.

1945 'The Psychiatric Social Worker's Concern with Shock Treatment', *The Newsletter of the American Association of Psychiatric Social Workers*, **15,** 13–17.

1946 'Employment of Neurotics', *J. Clin. Psychopathology*, **7,** 803–813.

1947 'Principles of Psychotherapy in Latent Schizophrenia', *Amer. J. Psychotherapy*, **1,** 129–144.

1947 'Professor Freud: The Beginning of a Case History', *Samikṣā*, **1,** 305–311.

1948 'Freud Amongst Us', *The Psychiatric Quarterly Supplement*, **22,** 1–6.

1949 'Mental Hygiene of the Ego (Abstract)', *Amer. J. Psychotherapy*, **3,** 290–291.

1949 'Mental Hygiene of the Psychotic Ego', *Amer. J. Psychotherapy*, **3,** 356–371.

1949 'Zur seelischen Hygiene des Ichs', *Die Psychohygiene. Grundlagen und Ziele.* (Berlin: Verlag H. Huber, Bern), pp. 17–24.

1949 'Psychoanalytic Prevention *Versus* Therapeutic Psychoanalysis', *Searchlights on Delinquency.* (New York: Int. Univ. Press) pp. 26–34.
Dedication [to August Aichhorn], *Ibid.*, pp. vii–viii.

BOOK REVIEWS

Collected Papers. Vol. V. By Sigmund Freud. Edited by James Strachey. No. 37, The International Psycho-Analytical Library, edited by Ernest Jones. (London: Hogarth Press and the Institute of Psycho-Analysis, 1950. Pp. 396. Price 25*s.* net.)

This volume completes the series of Freud's *Collected Papers* published in the International Psycho-Analytical Library. Its contents vary widely both in date and in subject matter, as the sub-title, 'Miscellaneous Papers, 1888–1938', implies. It includes papers written after the publication of Volume IV (1925) and gathers together a number of earlier ones omitted from Volumes I to IV, e.g. several Prefaces, the two *Encyclopædia Britannica* articles, and some dozen papers which now appear for the first time in English. The new and the revised translations conform to the exceptionally high standard we have come to associate with the work of James Strachey.

Readers unfamiliar with the German originals will be particularly interested in the new translations. The first consists of three preparatory drafts of the 1893 paper, 'On the Psychical Mechanism of Hysterical Phenomena', which appeared in *Collected Papers*, Vol. I. These drafts reveal Freud's mind at work on the initial clues afforded by his cases and show clearly the penetrative character of his insight and the firmness of his mental grasp. A second new translation, 'A Case of Successful Treatment by Hypnotism' (1893), marks his recognition of mental conflict in terms of 'counter-will'. It also contains a delightfully human description of his youthful reaction to the successfully treated patient's lack of appreciation: 'I found it hard to understand, however, as well as annoying, that no reference was ever made to my remarkable achievement.' A third, 'Screen Memories' (1899), ends with a passage which is still topical and relevant to discussion on the interpretation of infantile phantasies. A fourth new translation, 'A Note on the Prehistory of the Technique of Analysis' (1920), is of both human and scientific interest since it indicates the probable influence of his boyhood reading on Freud's later adoption of the technique of 'free association' and of the terms 'censor' and 'censorship'. The remainder of the new translations contain less that may be novel. The last, 'Some Elementary Lessons in Psycho-Analysis' (1938), was left unfinished and appears to be the beginning of a fresh version of the 'Outline of Psycho-Analysis'.

With the exception of the open letter to Einstein, 'Why War?', and the new translations, all the papers from 1925 onwards appeared in this *Journal*. They will, therefore, be familiar but are also too varied to comment on in detail. They range from short articles of mainly human interest, e.g. 'My Contact with Josef Popper-Lynkeus' (1932), and 'A Disturbance of Memory on the Acropolis' (1936), to major contributions such as 'Libidinal Types' (1931), which marks the first step towards an economic theory of personality differentiation, and 'Analysis Terminable and Interminable' (1937), with its addenda, 'Constructions in Analysis' (1938), and 'Splitting of the Ego in the Defensive Process' (1938). 'Female Sexuality' (1931) is Freud's last considered statement on this topic: he recognises a long pre-Œdipal period of attachment to the mother but still adheres to penis envy (*vide* 'Some Psychological Consequences of the Anatomical Distinction between the Sexes' (1925)), as an invariable primary factor in feminine development. Had he carried over his conception of 'repudiation of femininity' from men to women he would probably have become aware of the defensive rôle, and often secondary character, of penis envy and have ceased to regard it as a 'bed-rock' difficulty for therapy.

'Analysis Terminable and Interminable' has a special interest because it provides us with Freud's own evaluation, in retrospect, of psycho-analysis as a therapy. Hence, it is definitely a paper which should be read by every candidate-in-training in relation to current discussions on the process and criteria of psycho-analysis. A phrase in the second footnote on p. 327, 'It is impossible to define health except in terms of metapsychology', is an excellent example of Freud's habit of making almost casual asides which, nevertheless, often uncover the root of the matter.

In 1888 Freud wrote '. . . in some scientific matters it is always experience, and never authority without experience, that gives the final verdict . . .'. Freud's scientific authority is, indeed, based upon his creative interpretation of experience, though it remains the duty of every practitioner to test Freud's conclusions for himself in his own consulting-room. But it is the common experience of psycho-analysts that every re-reading of Freud tends to provide fresh stimulus to their thinking and often presents new clues formerly overlooked. This is only one of the reasons why it is such an excellent thing that the publication of this fifth volume of *Collected Papers* has made the whole of Freud's work available in English.

Marjorie Brierley.

Beyond the Pleasure Principle. By Sigmund Freud. A New Translation by James Strachey. No. 4, The International Psycho-Analytical Library, edited by Ernest Jones. (London: The Hogarth Press and Institute of Psycho-Analysis, 1950. Pp. 97. Price 7*s.* 6*d.*)

For some time past the new translations of Freud by James Strachey have been appearing at intervals. They will eventually form a complete and uniform series in which a consistent standpoint is maintained towards problems of terminology, indexing and bibliography. Concepts too can preserve their historical continuity as between one work and another, for Mr. Strachey knits the single topic as well as the single work into the series by cross-references. He hopes also to provide eventually a universal index which should serve this same purpose.

The value of the new series can be felt in the present volume. If the 1922 translation by C. J. M. Hubback is read chapter by chapter with the new one, Strachey's volume gives the impression that with the passage of years we are more at home with the work than we were in 1922. Freud's metaphors which were innovations then are familiar to us now. They do not any longer require the formal and to our ears pedantic handling which was accorded to them at first. The remoteness of German and of formal Latin is diminished: 'Antennæ' become 'Feelers' and 'W-Bw' becomes 'Pcpt-Cs'. Schmerz and Unlust are both rendered ' Unpleasure ' so that we do not any longer have to remember the difference between ' pain ' and pain as we did before. Nor are we in any risk to-day of confusing J. Breuer and S. Freud with any other pair of authors when their names appear without their initials.

In the new volume there are additional footnotes which give cross-references and emendatory notes, as for example on page 4 where there is a footnote upon the history of the Constancy principle. On page 72 Freud refers to opinions which he expressed earlier in the book and now wishes to amend. Mr. Strachey obligingly tells us that the earlier references were made upon pages 51 and 53. In all these little ways the thread of Freud's argument becomes much clearer to the present-day reader.

Less conspicuous but more fundamental is the way that passages in the new translation express meaning more clearly than they did before. At the top of page 39 of Hubback the meaning is obscure until one reads Strachey (page 41). And there is a second passage even more obscure elsewhere. This is not a matter of choice of words as in the following comparative passages. Hubback (page 74) gives: '. . . derives an instinct from the necessity for the reinstatement of an earlier situation '. Strachey renders this: '. . . traces the origin of an instinct to a need to restore an earlier state of things '.

The original notice of the Hubback translation appeared in 1922 (*Int. J. Psycho-Anal.*, 3). In this M. J. Eisler cautiously devotes most of a long review to a summary of what Freud says. He barely ventures any opinions. One point that impresses him, however, is that Freud has defined the Reality Principle scientifically for the first time by linking it to time which is a function of Pcpt-Cs. This is in contrast to the Pleasure Principle which obeys the Primary Process and so takes no account of time.

Twenty-nine years after the review we may think that M. J. Eisler speaks of ' Instincts ', ' Sadism ' and other concepts more animistically than we would think proper. But we can still enjoy what Eisler refers to as Freud's ' literary method ' and all the more for the sensitive and lively translation by Strachey. I quote from Eisler's review: ' Freud's literary method resembles that of art or philosophy (in) that the principal conclusions are embedded in the material of the exposition. That is to say, in the context . . . they can so to speak only be lifted with the clod of earth in which they have grown and in such a manner be transplanted. Psychological matters require the hand of a cautious gardener. . . .'

Martin James.

Fundamentals of Psychoanalysis. By Franz Alexander. (London: George Allen and Unwin, 1949. Pp. 312. Price 16*s.* net.)

' Confronted with the task of revising *The Medical Value of Psychoanalysis* for a third edition ', the author decided instead to write a new book in two volumes, of which *Fundamentals in Psychoanalysis* is the first: the second will discuss the psychosomatic approach to medicine.

This book is essentially a textbook for students based on courses of Introductory Lectures to Psychoanalysis delivered in the Chicago Institute for Psychoanalysis during the last fifteen years. It exhibits many of the features desirable in an introductory textbook, e.g. logical sequence, simple, clear and vigorous exposition, illustrations from case-histories, etc. Alexander has abandoned the usual historical approach, still considered by many the most fruitful, but stereotypy in teaching is admittedly no more desirable than stereotypy in practice. It is doubtful, however, whether this book will establish itself as a primer generally recognized by Training Committees. Individual accounts of psycho-analysis must differ since each will reflect its author's preferred approach. In this account, Alexander is often at pains to relate or to distinguish his personal conceptions to or from those of Freud and others. In spite of these mitigating considerations, the verdict of many psychoanalysts may well be that this volume is less a textbook of psycho-analysis as such than ' a concise and up-to-date presentation ' of Alexander's own views, some of which can only be described as highly controversial.

The basic trend which concerns the reviewer becomes apparent in the first chapter. Few psychoanalysts will doubt that ' psychology is related to biology ' or that thinking is ' one means of orienta-

tion in the external world ': the further statement that ' the functions of the mind can be understood as adjustments to the problem of orientation in the environment ' is more questionable. Whatever the significance of environmental pressures in the evolution of mind and in individual mental development, the primary rôle of mental life as we know it to-day is *mediation between* instinct and environment. Endopsychic adaptation is no whit less characteristic and indispensable a feature of this rôle than orientation to environment. Most of the views in this book likely to meet with adverse criticism seem to be related to this allocation of undue priority to external reality-adaptation, i.e. to a reverse tendency to that which, at one time, seemed to threaten the British Psycho-Analytical Society.

It is one thing to agree with Freud's warning about too rigid a structural demarcation of mental organizations but quite another to discard the structural approach in favour of a behaviourist definition of the ego in terms of its functions, even though no psycho-analyst is likely to deny to the ego the three functions of ' external and internal perception, integration, and executive action '. Alexander, indeed, continues to recognize the existence of the super-ego as a ' disciplinary force ' or ' internal code ', developed by identifications with the parents, ' which is indispensable for social order ' but ' is in most people not a wholly adequate substitute for actual authority '. He prefers, however, ' to distinguish between more and less automatic emotional reactions and behaviour rather than between a completely automatic superego and a conscious, more flexible ego '. This is an oversimplification which dispenses with the intricate albeit vital problems of inter-systemic relationships.

It is also true that Alexander recognizes the developmental importance of the child's early experiences and relationships; he lays almost too much rather than too little stress on the pathogenic effects of repression. But the constant recurrence of the *motif* of adaptive behaviour to the external world seems to reduce the major psychological realities to minor themes. It leads eventually to the ' relativistic interpretation of neurosis ' which ' must always be defined as a relationship between a personality and its social setting '. Alexander does not say that a neurosis becomes manifest but that it ' sets in when heredity and infantile experience combine with the environment '. Such a definition of neurosis will be unacceptable to many psychoanalysts, and their misgivings will not be allayed by the short concluding chapter on ' The Principles of Psychoanalytic Therapy '.

The experiments in therapy in progress at the Chicago Institute which have been criticized by other workers (e.g. by K. R. Eissler) are naturally not described in detail. However, many analytical readers will consider that the recommendations for first interviews given here are better suited to consultants trying to determine whether to recommend psycho-analysis or some other method of psychotherapy rather than to practitioners conducting the initial sessions of an analysis. What should be called psycho-analysis is, as Alexander says, a matter of definition but to many it will still seem advisable to distinguish the radical process from derivative, ameliorative methods which may be devised as a result of psycho-analytic knowledge. Freud described the radical process as reclamation work, but, whatever our preferred individual descriptions, it is commonly recognized that the strengthening of the ego which results is only a part of the profound economic changes which take place in the total personality. It is the improved internal adaptation, rather than the success story by itself, which is the criterion of improvement in mental health. Techniques which aim at rendering the patient socially viable by the shortest route may have many legitimate uses but they should not be confused with, or regarded as substitutes for, the radical process of psycho-analysis. The assumptions underlying the Chicago experiments may be conveyed by two brief quotations: ' Modern psychoanalytic therapy relies mainly on the handling of the transference ', i.e. not on the *analysis* of the transference; ' Repression makes the adjustment of instincts impossible. When it has been overcome the ego can modify and sublimate the mental energy expended on psychoneurotic symptoms.' An obvious comment is that the ego can lead its instinctual horse to likely water but cannot make it drink.

This review has dealt briefly only with the suitability of this volume as an introductory textbook for the use of candidates-in-training: many more points might have been raised on this issue alone. There are also many topics of interest in it which have not been mentioned, e.g. an excellent chapter on Sociological Considerations and a number of stimulating though controversial discussions on matters relating to problems of instinct. In the past Alexander made valuable contributions to psycho-analysis; thus, he was the first to state explicitly that Freud's modern views on the organizational structure of the psyche entailed henceforward the analysis of the total personality. He states that he owes a great debt to his students but it is difficult to avoid the conclusion that they have also done him a disservice. It would seem that the effort to render the fundamentals assimilable by his students has led insidiously to an Americanization of the fundamentals themselves. At any rate the cultural climate of Chicago seems to favour emphasis on external reality as compared with endopsychic adaptation, on doing well rather than on becoming whole.

Marjorie Brierley.

Emotions and Memory. By David Rapaport. The Menninger Clinic Monograph Series No. 2.

Second Unaltered Edition. (New York: International Universities Press, 1950.)

David Rapaport has given us a psychologist's view of the interrelationships between emotions and memory. In this scholarly work, he has attempted to correlate the views of classical psychology, experimental psychology and the growing body of psycho-analytic knowledge. This he accomplishes with a rare ability to work within a multiplicity of frames of reference, and he successfully overrides the problem of varying and sometimes apparently contradictory terminologies. While he honestly labels the volume a preliminary effort, there is much that the clinically trained psycho-analyst can learn from this book about the work of scientists in related fields. Rapaport promises us another volume in the near future, and we look forward with eager anticipation to his further efforts. For the problem of memory (and its emotional repression) lies at the very cornerstone of psycho-analytic theory, and is the basis on which Freud built his theory of the unconscious. Perhaps the psycho-analytic world has accepted these basic postulates too uncritically—and perhaps not. The work of Rapaport and others like him, capable of working in borderline disciplines, will offer us the answer.

Milton R. Sapirstein.

The Book of the It. By Georg Groddeck. Translated by V. M. E. Collins, M.A. (New York: Funk and Wagnalls Company.)

Das Buch vom Es was first published by the Psychoanalytischer Verlag in Vienna in 1923. It is a collection of thirty-three letters, all variations on one central theme—Groddeck's concept of the ' wondrous force ' which directs man, ' both what he himself does, and what happens to him '. To this force Groddeck, probably adapting Nietzsche's terminology, gave the name ' Es '.

When *The Ego and the Id* appeared—also in 1923—Freud took over the term ' Es ', and at the same time paid a generous tribute to Groddeck. Freud wrote as follows: ' Now I think we shall gain a great deal by following the suggestion of a writer who, from personal motives, vainly insists that he has nothing to do with the rigours of pure science. I am speaking of Georg Groddeck, who is never tired of pointing out that the conduct through life of what we call our ego is essentially passive, and that, as he expresses it, we are " lived " by unknown and uncontrollable forces. We have all had impressions of the same kind, even though they may not have overwhelmed us to the exclusion of all others, and we need feel no hesitation in finding a place for Groddeck's discovery in the fabric of science.' [1]

Without depreciating this tribute, it is however difficult, in the perspective of almost thirty years from its publication, to review *The Book of the It* as a contribution to science. At first glance it appears to deal with familiar psycho-analytic concepts; but very soon one realizes that Groddeck's It is something very different from the Id of accepted psycho-analytical terminology. The It described by Groddeck is a mysterious, all-embracing force, whose nature, despite profuse elaboration, remains hazy and ambiguous. One looks in vain in his description for the developmental, dynamic, structural and economic aspects of the mind. Groddeck remains content with specious generalizations, and is either unable or unwilling to attempt further elucidation. Though he pays scant attention to the nature of the Ego and its functions, he affirms paradoxically that access to the It is possible only by means of Psycho-analysis—that is, through the Ego systems.

Groddeck does not allow any differentiation between mental and organic illness. In his view, mental disturbances, a running nose, a broken skull, retinal hæmorrhage, pulmonary tuberculosis, and cancer are all manifestations of the power of the It. ' For the It there is no distinction between organic and mental, and consequently . . . if the It can be influenced by analysis, even organic diseases can, and in certain circumstances must, be treated psychoanalytically.' [2] He envisages a day when through psycho-analysis it may be possible to regrow amputated limbs.

Yet *The Book of the It* still holds great interest for the psycho-analytic public. Groddeck combined an exceptional feeling for the unconscious, an intuitive gift for the interpretation of symbols, with the ability of the creative artist to express himself in a vigorous and provocative style. Groddeck's work will be remembered not only because of his contribution of the term ' Es ', but because he was one of the most forceful propagandists in the early struggles of the psycho-analytic movement, and gave valuable impetus to investigation and research in the field of psycho-somatic medicine.

Alexander Bromley.

Exploring the Unconscious. By. Georg Groddeck. (London: Vision Press Ltd., 1950.)

The Book of the It. By Georg Groddeck. (London: Vision Press Ltd., 1950.)

Two old and dear friends in a new form changed from German into English. *The Book of the It* is one of my favourite books, perhaps the very first writing in medicine that took seriously the idea that illnesses which impress us as somatic or organic are caused by emotions, in fact are un-understood or misinterpreted expressions of emotions. The form chosen to convey this message to us is that of letters written by a doctor, Patrick Troll, to his

[1] *The Ego and the Id,* 3rd edition, p. 27.

[2] *The Book of the It,* p. 138.

friend who in real life became Groddeck's wife, collaborator and true life-companion. Now, more than a quarter of a century after its first appearance, it is perhaps necessary to say that it was from Groddeck and this book that Freud borrowed the term *Es* (= Id). True to Groddeck's spirit, the translator has refused to accept the Latin 'Id', and has kept faith with 'It'.

The contents of the other book are less well known in psycho-analytic circles. So far as I can see they are in the main a selection of papers which appeared in *Arche*, a private periodical mainly written and almost entirely financed by Groddeck. Its readers were almost exclusively Groddeck's friends and former patients, and it is very welcome that they have been made accessible, at least in part, to a wider public.

The translation is free and easy, following Groddeck's style as far as possible; but perhaps it would have been wiser to translate 'Brust' by 'Chest' instead of 'Breast'. It is, after all, rather ambiguous to say that one's heart is in one's breast.

Michael Balint.

Tensions Affecting International Understanding. By Otto Klineberg. (New York: Social Science Research Council, 1950. Price $2.25.)

Tensions That Cause Wars. Edited by Hadley Cantril. (University of Illinois Press, 1950. Price $4.00.)

Professor Klineberg's book is a veritable goldmine of information. The whole field of experimental group tension research is admirably summed up here, not merely reviewed but each contribution critically evaluated. Looking back at the work done and in progress one cannot help having rather mixed feelings. All that has been or is being done is honest work, obviously needing to be done; and yet the sum-total of it all amounts to very little. It is as if the workers, consciously or unconsciously, had fought shy of every relevant issue, of every really burning problem.

One of the reasons for this is psychological. Since most field workers used either questionnaires or completion tests, both questions and answers had to be somewhat superficial, allowing only occasional glimpses into the deep cleavages separating the various groups from each other.

A second reason is lop-sided selection of material and problems. The workers' main concern was the attitude of the literate classes towards other classes. This is only one consequence of their use of questionnaires and completion tests. Obviously a grammar-school education qualifies better for such a survey than illiteracy or, say, literacy not going beyond the level of the comic strip. But perhaps the workers' own background militated also, albeit unconsciously, against extending their survey to the attitude of such oppressed classes as the destitute proletariat, illiterate Negroes, Lascar seamen, and so on.

The third reason is obviously political. This is brought glaringly to light in the second book under review, a very remarkable one, written by nine contributors: the convener, Hadley Cantril, and eight participants (amongst them John Rickman as the psycho-analyst) who tried to thrash out their differences of opinion at a round table conference organized by Unesco in the summer of 1948. All were 'social scientists', seven of them from the West, one from Hungary, which at that time, although communist, was not yet completely behind the iron curtain. The seven Westerners, although sharply criticizing each other, were able to speak a common language. The procedure was this. After discussions lasting for a fortnight a common statement was agreed on; then each participant was asked to sum up his point of view in about five thousand words, and each manuscript was circulated among all the other participants, who were allowed to make short comments in writing. The book contains all this material, together with a postscript by Professor Szalai, the Marxist sociologist, a privilege which was not granted to any other participant. This postscript includes the sentence: 'Some statements have been made here in print which—had they been made in the conference room without a heavy rebuke from the chairman—would have forced the author of these lines to interrupt violently, or even to walk out of the conference room.' Let us contrast this sentence with Professor Klineberg's concluding paragraph: 'Unesco is in the fortunate position of being able to bring together scientists from different countries and from different disciplines and to facilitate the necessary work of integration. It can do little, however, unless it can count on the support of social scientists everywhere. The writer can only express the hope that this review, though incomplete, of what has already been done may stimulate others to make their scientific contribution to a field of inquiry which is of fundamental importance for international relations.'

Professor Szalai's remark quoted above, as well as the spirit of his comments in the book, do not augur well for 'the necessary work of integration'. It is true, however—and it is a great pity that it is true—that the seven Western social scientists were incautious enough to offer to Professor Szalai in their contributions a number of weak points which with some care and attention might largely have been avoided. It is still more correct to say that the conscious control of their accustomed automatic way of thinking was not efficient enough to steer clear of the pitfalls of possible misinterpretation by a Marxist thinker, thereby leading to unnecessary 'Tensions Causing (scientific) Wars'. On the other hand, Professor Szalai seems to have heartily welcomed every such opportunity.

Apart from this unfortunate negligence the material presented is instructive and impressive. Rickman's chapter is an interesting attempt at examining the dynamics of social (institutional) and individual defences against the aftermath of environmental frustration and general aggressiveness.

Michael Balint.

Applied Psychoanalysis. Selected Objectives of Psychotherapy. By Felix Deutsch, M.D. (New York: Grune and Stratton, 1949.)

This book is the outcome of experiments in the treatment of neuroses undertaken by a number of members of the Boston Psychoanalytic Society during the last war. It represents one of the many ways in which the experiences of fully-fledged psycho-analytic treatment can be applied to brief psychotherapy. It has the great advantage of being written by someone who is himself a psycho-analyst and thoroughly familiar both with the technique and its concepts.

This method aims at goal-limited adjustment, and has developed its therapeutic procedure, called ' Sector Therapy ', from an interviewing technique which has been described as ' associative anamnesis '. This means that the approach aims at uncovering less conscious material by letting the patient drift into a kind of thought production under relaxed conscious control. Certain words are pressed home for further associated ideas from the patient, for instance, because they have been repeatedly used or appear to have a special meaning. The therapeutic approach is meant to remain centred around certain symptoms or conflicts. The therapist uses confrontation of the patient with the material produced by him, in preference to interpretation. Many further technical hints are given, which the experienced psycho-analyst knows more by way of episodes during full psycho-analytic treatment. The theory of this therapy stresses a kind of thinning out of cathexis by displacement, and a loosening up of chains of association. ' The dissolution of these chains and replacement by new ones is, in fact, the therapeutic process.' Confession in symbolic language, which may be unnoticeably transformed into the real meaning, is recognized as a potent factor. Transference and its handling, which is one of the key problems of all these brief forms of psychotherapy, is not much mentioned, and certainly an analysis of the transference situation is not contemplated. But it is noticeable how, albeit implicitly, Felix Deutsch reverts to the social nature of neurosis. It usually happens that, with the uncovering of emotional material, references to one or other person in the patient's environment, present or past, appear. This stage is deemed to be critical, because the three essential points in establishing the case history are stated to be ' the old conflict, the present conflict and the time factors '. In psychosomatic disorders, for instance, for which this Sector Therapy is considered the method of choice, somatic symptoms and emotional symptoms with reference to this ' relevant person ' are used as word stimuli for new thoughts. From here the patient himself usually correlates the organic illness with his emotional life. This form of therapy is said to be effective likewise in anxiety neuroses or phobias, but more difficult to apply in the obsessional neuroses, as one would expect.

The main part of the book contains accounts of interviews, which were apparently recorded verbatim, and form the most valuable illustrations. They refer to two cases. The first case is represented by an account of an interview of half-an-hour's duration and is presented mainly in order to demonstrate the technique. In the second case, all the interviews, a total of fourteen, are reported. The book further contains short sections on Psychiatry and Social Welfare, on Mental Health in Industry, and on Family Disruption, with short, characteristic illustrations. The last-named section is of particular interest. It deals with various types of neurotic reaction on the part of married couples due to separation owing to the war. The following reaction patterns are noted: (1) masculine protest; (2) homosexual manifestation; (3) overcompensation of the feminine rôle; (4) prostitute-like behaviour; (5) revengeful behaviour against the ' desertion '; (6) phobias and nightmares; (7) abandonment or neglect of the children, or inability to manage them; (8) flight into the old family situation. These different types of reaction are summarized under the name of ' separation neurosis '. Observation confirmed the classical findings of psycho-analysis, namely that the pattern depends on the underlying latent or manifest neurosis before the separation occurs.

On the whole, a very readable little book and a very useful account of one of the many ways in which psycho-analytic knowledge and experience can be legitimately applied.

S. H. Foulkes.

An Introduction to Personality Study. By Raymond B. Cattell. (London: Hutchinson's University Library, 1950. Pp. vii + 235. Price 7*s.* 6*d.*)

This book admirably fulfils the author's aim, which, he says, ' has been to bring the general problems of personality description and development, normal and abnormal, into a single perspective and to integrate the principal fields of observation in clear-cut generalizations ' (p. 9). The scope of the book may be most readily conveyed by listing the main chapter headings: (I) Problems of Personality Study; (II) Inherited, Constitutional Influences in Personality; (III) Psychodynamics: I. The Rise of Normal Personality Structures; (IV) Psychodynamics: II. Further Analysis of Basic Structures and Functions; (V) Psycho-

dynamics: III. The Progress of Adjustment or Maladjustment; (VI) The Abnormal Personality, Neurotic and Psychotic; (VII) The Description of Personality; (VIII) The Measurement of Personality; (IX) Personality and the Body: Psychosomatics; (X) Personality and the Cultural Pattern; (XI) The Life Course of Personality. Each chapter is a concentrated meal but too well written to be indigestible. A fuller Subject Index would have been an advantage in a volume covering so much ground. The reviewer was puzzled by an item in Table 4 (14, p. 71) which attributes to man an innate propensity ' to present resistance to the expression of any propensity; to attack and destroy such resistance '. It would seem that a redundant ' p ' has crept in and that the item should read ' To resent resistance, etc.'. Although the book is intended primarily as a small standard textbook for University students, each chapter ending with a Summary and Suggestions for More Advanced Reading, it offers relatively easy access to the author's basic principles and methods of research and may be read with advantage by psycho-analysts who may have little time or inclination to study the 689 pages of his larger work, *Personality: A Systematic Theoretical and Factual Study* (McGraw Hill, 1950).

Cattell's views on the dynamic structure and development of personality clearly owe much to psycho-analysis and also to the work of Shand and McDougall. He adopts some familiar terms, but often prefers to introduce new ones, and has re-cast the probable story of development for himself. He uses the term ' erg ' in place of primary instinct-impulse or drive, a choice provoking to natural scientists, because ' erg ' has long been used in physics with a precise quantitative definition referring to work done under specific conditions. Psycho-analysts will sometimes think the author's transcriptions unnecessary, e.g. that the term ' motivation ' would have served as well as the new-minted ' subsidiation ' and have avoided another addition to the confusion of tongues in psychology. However, Cattell uses his preferred terms to good effect in clear and logical exposition. Extracts from the ' Summary Concerning Dynamic Structure ' (pp. 66–67) will convey his approach and usage of words in a nutshell. Thus ' (1) Dynamic traits are structures inferred from the fact that the individual is repeatedly motivated to behaviour in certain stereotyped ways. (2) Dynamic traits consist of attitudes (or interests) which are subsidiated in turn to basic biological principles called ergs or drives. Attitudes and sentiments derive their motivation from ergs and may be called collectively metanergs. They form a dynamic lattice, showing subsidiation, equivalence and transflux. . . . (6) Consideration of repression and neurotic symptoms calls attention to internal, intrapsychic conflict in the individual, which is described most economically by considering all dynamic traits to fall into three broad structural groupings, the ego, the id and the super-ego. The first is wholly conscious, the second wholly unconscious, and the third partly conscious, partly unconscious.'

Though sympathetic to many findings of psycho-analysis and far from dismissing clinical and other observational methods as valueless, Cattell regards measurement as the only procedure that can yield valid and reliable objective knowledge. Hence his conviction of the need for mathematico-experimental research, his desire for psychometric proof of clinical findings and his hope that ' a calculus of dynamic personality structure ' may become possible. He prefers a ' denotative ' definition of personality as ' *that which determines behaviour in a defined situation* ' and offers (p. 222) a type of equation that has already proved useful in predicting individual behaviour, especially in the field of abilities. This formula ' suggests that no item of performance by the individual is unaffected by all aspects of the individual make-up, and the same is probably true of personality development '. His methodology is based on the correlation-coefficient techniques used by Spearman and others, expanded and supplemented by geometrical and graphic methods. Thus (p. 66 (4)) ' An attitude or any other dynamic trait can be represented for purposes of calculation as a vector, defined both as to direction and strength. The strength is the strength of the interest concerned, to be measured by the work it accomplishes. The direction is defined by co-ordinates corresponding to the basic ergs— . . . The method of factor analysis . . . can give . . . the involvement in any attitude of the various ergs (general factors) and also the pattern of organization of attitudes in acquired sentiments (group factors).' The present reviewer is not competent to assess the mathematical and technical validity of these methods but, judging by their results, they appear to be the most promising yet employed in psychometrics. It is by no means easy to devise adequate objective tests for all suspected traits. If the present state of an individual and even what he is likely to become under given conditions prove amenable to measurement, the difficulties in the way of mathematical expression of the course of development may be very great indeed. In short, the difficulty of testing ' genetic propositions ' experimentally, discussed by Hartmann and Kris in relation to ' field theory ', appears to hold good of ' factor analysis '. Inference from observation still plays a large part in Cattell's own version of the story of development and indeed understanding of the character of a given individual depends greatly on interpretation of ' measurements '.

About a dozen unitary source traits are thought to exist, but only some four of the best established of these personality factors are dealt with in this book. One of the most important of these is Factor (C), the factor of dynamic integration, whose quantitative variation, positive to negative, affords

a measure of emotional integration or character stability. Cattell is unwilling at this time to venture further interpretations of this factor, but suggests it may evidence the normal integration of ego and conscious super-ego in the ' self-regarding sentiment ' (p. 88). Psycho-analysts may surmise that it may prove to be a measure of integration of the total personality, rather than of ego stability as such. If this should be the case (C) measurement might prove one useful index of degree of mental health or disorder and an aid in diagnosis, e.g. in cases where concealed psychosis is suspected in apparent neurosis. The correlation between (C) and (B), the intelligence factor comprising general ability ' g ', is unexpectedly high, though it has long been known that mental deficiency and delinquency tend to be associated.

Factor (F), Surgency-Desurgency or Hysteria-Dysthymia, is positive to excess in hysteria and mania and lowest in anxiety neuroses and agitated melancholia. It is thought that this factor may be the axis along which manic-depressives oscillate. Cattell also suggests that the superego is evidenced by this factor, though clinicians may wonder if it does not evidence the nature of prevailing ego-superego relationships.

Factor (E), Dominance-Submission, and Factor (I), Sensitive Emotionality—Hard Poise are considered together. A satisfactory objective test for (E) is still lacking. Cattell thinks this may be because this trait is ' so purely social in character ' and that it is the ego which is evidenced by it. This may well be so, but psycho-analysts are bound to think that intra-psychic relationships are also much involved here, particularly the distribution of aggression and the modes of its disposal, e.g. the balance of introjective and projective defence-mechanisms. (I) is said to be a subtle but powerful contributor to personality variance, possibly identifiable with hyperthyroidism or the hormone determinants of masculinity or femininity. The three source traits (E), (F) and (C) are slightly positively correlated, compatibly with the existence of a single underlying factor or temperamental disposition, ' ergic rigidity ', which psycho-analysts know by its opposite, ' lability '. This underlying factor is called a factor of the second order, which is potentially confusing to readers accustomed to the psycho-analytic usage of ' primary ' and ' secondary '.

Cattell himself recognizes fully that the measurement of personality is only in its initial stages, and he is in no hurry to force interpretations or to preclude future modifications of present conclusions. It is greatly to be hoped that his co-workers and students in this field will show equal restraint and not lend themselves to premature standardization or rigidity in the interpretation of their results. The book is full of matter for discussion, but it is hoped that this brief review may indicate that the work in progress in this field is of considerable interest to psycho-analysts, not least because Cattell's technique seems to offer prospects of ' experimental validation ' in some directions, if not in all. His own conclusion is that ' personality is the integration of the partial reactions of the organism, but it promises also to be the integration of psychology '.

Marjorie Brierley.

The Explanation of Life. By Stephan Thyssen Bornemisza, Ph.D. (Zürich: Rascher, 1949. Pp. 272.)

The omniscient flavour of the title, not to mention the writer's name and the fact that he accepted the Chair of Applied Geophysics at Münster University, Westphalia, in 1938, may tend to prejudice English-speaking readers against this book. It should, however, be remembered that the author is a physicist of world repute, a pupil of Max Planck (to whose memory the volume is dedicated) with about seventy publications to his credit not only in geophysics but in other fields such as biochemistry and plant physiology. For a man of such ability and experience to try to provide ' The real Background to Nature ', and a firm foundation for the structure of the natural sciences, may be ambitious, but it is a natural outcome of a strong philosophical bent in a scientifically trained and well provisioned mind. The author's argument is too closely knit to broach in a short notice and the book will have too little appeal to clinicians to justify a long review in this journal. It will nevertheless be of considerable interest to any psycho-analysts who are intrigued with the inter-relationships of the sciences and with what is usually called the philosophy of science.

Marjorie Brierley.

The Liberal Imagination. Essays on Literature and Society. By Lionel Trilling. (New York: Viking Press, 1950.)

The American liberal tends towards a simplistic view of life. Hence liberalism, according to Trilling, must be reformed from within. If it is to remain a productive force, it must be recalled to its first essential awareness of ' variousness, possibility, complexity and difficulty '. Freud's place within this general framework is evident. His view of life—as Trilling sees it—culminates in ' the idea of the reality principle ' and in ' the idea of the death-instinct '. A ' grim poetry ', a ' classic tragic realism ' pervade his psychology, which does not narrow and simplify the human world for the artist but on the contrary opens and complicates it.

Trilling's essays on ' Freud and Literature ', on ' Art and Neurosis ', and, especially, on ' The Kinsey Report ' and its sociological significance, prove that the author has assimilated the psycho-analytic approach to an extent which is—as yet—rare among laymen. Indeed, Trilling stands on

Freudian ground. However, as a literary scholar he is primarily concerned with the limitations of a psycho-analytic interpretation of literature, with the fallacies to which Freud was subject in his earlier views on art and the artist, and, generally, with the toning-down of direct relationships between analysis and literature.

Thus he finds that, apart from the general debt which analysis owes to the poets as original discoverers of the unconscious, the major discoveries of Freud can scarcely be traced to any literary precursors, but should be regarded as an expression of that same *Zeitgeist* which gave rise to the works of Proust, who, on his part, had not been acquainted with the works of Freud. Similarly, Trilling maintains that, apart from a general, pervasive infiltration of psycho-analysis into our modern view of life, few major post-Freudian writers have made serious and systematic use of Freud's ideas. Nor—Trilling continues—did psycho-analysis produce an adequate concept of art, which Freud defined as a substitute gratification, an illusion, a —usually harmless and beneficent—narcotic. To be sure, for the didactic purpose of therapy, Freud required somewhat crude distinctions between the 'polar extremes' of ('honorific') reality and ('pejorative') illusion. Yet as a theorist he knew that the neurotic patient was to be reconciled with what was, after all, 'a "taken" and not a "given" reality', i.e. with the reality of love, morality, esteem, of social life and value, conceived and maintained by the human mind and will. 'If we are to call art an illusion, then we must call most of the activities and satisfactions of the ego illusions.' Freud overrated the analogy between such phenomena as day-dreams, dreams and neurosis on the one hand, and art on the other. The poet, unlike the dreamer or the neurotic, is in command of his fantasy, and the work of art—as Barzun put it —'leads us back to the outer reality by taking account of it'. Freud's 'assumption of the almost exclusively hedonistic nature and purpose of art bars him from the perception of this'.

Closely related to this alleged misconception of art are the misconception of the artist as a neurotic and the fallacy according to which the root of artistic power lies in a traumatic experience. Trilling believes that the myth of an inevitable connexion between genius and disease is rampant among the literary men and among the 'sensitive people' or half-artists rather than among the more enlightened contemporary psycho-analysts. The neurosis of the artist, he argues, may explain the preoccupation with certain themes and, perhaps, reveal some reasons why the artist brings his power into play. It can tell us nothing about the artist's skill and gift. If anything is healthy about the artist it is precisely his capacity to conceive and to create works of art. As for the artist's affliction, Freud's concept of illness is quantitative, or, to put it differently, Freud himself finds that, leaving aside the question of degree, 'we are all ill'. Yet if 'neurosis can account for everything, for failure and mediocrity—"a very serious impoverishment of available mental energy"—as well as for genius, it cannot uniquely account for genius'. Pain and conflict are omnipresent. Neither the uniqueness nor the 'significance and intensity' of a neurosis can explain artistic genius. The artist is what he is by virtue of his 'successful objectivation' of his inner conflict, by his 'shaping it and making it available to others in a way which has its effect upon their own egos in struggle. His genius . . . may be defined in terms of his faculties of perception, representation, and realization, and in these terms alone.'

In examining the application of the analytic method to specific works of art Trilling repeats the objections which prompt him to reject the above-mentioned generalizations of Freudians and pseudo-Freudians. He insists that Freud and Jones could not have discovered 'the' meaning of *Hamlet*, because 'there is no single meaning to any work of art'. The meanings of a work of art cannot be divorced from its effect. However, the latter is representative of a multiplicity of interrelated factors within the work and it is also a variable, it is co-determined by changes in historical context and personal mood. Freud—Trilling claims—treats the 'mystery of Hamlet's effect' as if it had been always the same and as if it had been brought about solely by the magical power of the œdipus motive. And yet we know of periods and nations which remained indifferent towards *Hamlet*, and it is evident that innumerable works which elaborate and disguise the œdipus motive produce effects entirely different from that of Shakespeare's tragedy. This dilemma might be avoided if we could restrict our interpretation to the author's 'unconscious intention', but the latter—'as it exists apart from the work'—cannot be investigated. Even if the dream-analogy were granted, Freud himself warns us not to interpret a dream without the dreamer's free association.

Actually Trilling is quite unwilling to grant this analogy. In fact, he objects to the search for a hidden motive and a 'deeper meaning' if and when this search implies that there is a reality to which the work of art stands in the relation that the dream stands in to the wish that generates it. Shakespeare with his *Hamlet* meant *Hamlet* and nothing less. It is *Hamlet* which affects us, not the œdipus motive. Or rather: our unconscious response to the latter enters only as one determinant into a complex, total effect. Here, as in the case of the liberal ideology, Trilling does not wish to discard but to integrate. He seeks to include the analytical approach to literature, to rob it of any claim to exclusive validity and to refine upon its frequently contradictory and confusing terminology.

We must add at this point that the two essays pertinent in this context also include a detailed

discussion of what the author considers to be the positive contributions of analysis to the understanding of literature. However, the author's agreement with well-established propositions seemed to us of less interest than his critique, except, perhaps, in one instance in which Trilling asserts that Freud's treatise *Beyond the Pleasure Principle* suggests a function of tragedy other than, and additional to, the Aristotelian catharsis. According to Trilling, tragedy, like certain dreams and games which repeat traumatic experiences, is used as the homœopathic administration of pain to inure us to the greater pain which life forces upon us.

Trilling's satisfaction with this discovery of a truly adult function of dramatic art again reveals the conscious or unconscious intention which guides the author in his thoughtful, if incomplete, summaries. He cannot tolerate a view which would make art exclusively or even predominantly subject to the pleasure principle. The artist *qua* artist should be healthy. Art must not be an escape from reality. The author, who first became known through a book on Matthew Arnold and who has recently published a political novel, insists that literature can and should contain a criticism of our existence and that the novel should depict the large, ideological conflicts of the contemporary world. A strong emotional investment lends to Trilling's critique of psycho-analytical ' prejudices ' a note of personal urgency. And though, in his eagerness, the author at times relies on the accumulation of arguments rather than on the pursuit of a single, consistent, and cogent line of reasoning, he impresses us with a unity and force which stem from the persistent intention to deny the writer the pains and comforts of bad conscience, to deny him the excuse of neuroticism and to claim for literature an eminent place among the great agencies which help men to find their bearings in the complex human reality of this age.

Peter Heller.

Das autogene Training (*Konzentrative Selbstentspannung*). [Autogenic Training (Concentrative Self-relaxation).] By I. H. Schultz. (Stuttgart: Georg Thieme Verlag, 1950. Pp. 328. Price DM. 27.)

The principle of this method is the use of muscular relaxation for the purpose of emotional reconditioning. It aims at helping the individual towards acquiring the capacity for regulating autonomous organic functions by muscular exercises carried out in a state of active withdrawal from external stimuli. A sleep-like condition is produced, at first by the therapist and later by the subject himself, which brings about a ' lowering of affective resonance '. In this state certain changes in the peripheral vascular system take place, the pain threshold is raised, and cataleptic phenomena may appear. The author has found his method helpful in the so-called psychosomatic disorders, in insomnia, and in neurotic conditions associated with muscular tension. In other neuroses autogenic training had to be preceded by psycho-analytic treatment. Autogenic training, which the author has practised for the last thirty years, is the therapeutic application of the principles underlying Yoga, and was evolved from O. Vogt's observations on autohypnosis which had been inspired by Bernheim. The author discusses E. Jacobson's ' progressive relaxation ', which is based on similar ideas. Professor Schultz considers the physiological and psychological aspects of his method in the light of present-day knowledge of psycho-physical relations. He also attempts to integrate them with observations on the effects of nervous tension on the muscular apparatus reported by psychoanalysts. He suggests that his method could be beneficial as a means of prophylaxis against the development of nervous tension states.

There is a great deal in Professor Schultz's observations that is of interest for psycho-analysts, especially for those interested in psycho-physical relations and in the body image. Others may find that the author has not made sufficient use of the opportunity for exploring the patient's phantasies during the state of relaxation.

E. Stengel.

Medizinische Psychologie (Medical Psychology). By E. Kretschmer. (10th improved and enlarged edition, 1950. Pp. 304. Price DM. 24.)

This book by the distinguished German psychiatrist has enjoyed considerable popularity ever since it made its first appearance nearly thirty years ago. It aims at being informative rather than thought-provoking. It makes a great deal of what the author regards as the firmly established body of knowledge, and leaves little room for the problematic and controversial. The book is divided into five parts. Part I deals with the chief mental functions and their structural substrates. Perceptions, Gestalt formation, memory, thinking, consciousness and their neurophysiology are discussed. Part II deals with normal and abnormal affectivity, dreams and the problem of the Unconscious (the author prefers Schilder's concept of the ' sphere '). Part III presents the author's views on instincts (Triebe) and temperaments. He regards the following instincts as established: (1) the feeding instinct, among which he includes oral and anal tendencies; (2) the instincts of self-protection, which manifest themselves in aggression, defence and flight; (3) the sexual instincts; (4) the urge for movement; (5) the instinctual needs arising from the central regulation of sleep and wakefulness. The author allows for several more tendencies allied to instincts, such as the herd instinct. Part IV deals with personality types and psychopathic reactions. Part V, entitled ' Practical Medical Psychology ', is mainly devoted

to psychotherapy. The author has accepted most of the basic psycho-analytical concepts, but he warns the practitioner against being guided by any specific theory. He is in favour of the widest possible eclecticism. The reader is given the impression that with some knowledge of a great variety of methods, and with therapeutic enthusiasm, success is easy of achievement. Kretschmer has a kind word for practically every method that has ever been employed in the treatment of neurotic conditions. He has found all of them useful. He admits the need for ' analysis ' in many cases, but is satisfied with a very superficial type. ' Analysis ' is to precede persuasion. Of analytical methods he uses exploration by interview, association experiments, free associations, catharsis in superficial hypnosis and the Rorschach test. By being at first passive and later ' psychogogic ' (i.e. re-educative) he claims to be able to ' rebuild the personality '. Only exceptionally, in the author's experience, does treatment need to take more than two months. Transference is avoided or ignored. Kretschmer speaks highly of the ' training methods ' (Yoga, autogenic training). He does not state his criteria of therapeutic success. The inexperienced reader is bound to form the impression that a neurosis is not a serious matter at all. There is much in the chapter on psychotherapy that is superficial. Nevertheless, it has the virtue of open-mindedness and therapeutic optimism, both of which are rare among German professors of psychiatry.

E. Stengel.

Brain and Behaviour. (Induction as a Fundamental Mechanism of Neuropsychic Activity.) By N. E. Ischlondsky. (London: Henry Kimpton, 1949. Pp. 182. Price 21*s*.)

The author, who is a neuro-physiologist of the Pavlov school, understands most, if not all, of the complexities of human behaviour as manifestations of a basic physiological mechanism, i.e. induction. If a focus of excitation is produced in the central nervous system it gives rise, under certain conditions, to a focus of inhibition (negative induction) and *vice versa* (positive induction). The induced process may take place either during the existence of the ' primary focus ' at a certain distance from it (spatial induction), or it may appear at the site of the ' primary process ' following the latter (temporal induction). Brücke was the first to describe this mechanism in his treatise on physiological optics. Ewald Hering demonstrated it in his experimental studies on after-images. Reciprocal innervation and rebound phenomena (Sherrington) and increased excitability following an inhibitory process (Pavlov) are regarded as manifestations of the same mechanism. Ischlondsky illustrates induction by experiments of his own, using visual, thermal and painful sensory stimuli. He puts foreward the thesis that induction is at the root of everything that is contradictory and antithetical in human behaviour. The spitefulness and moodiness of children, the reading of forbidden books and the playing of tricks on teachers are instances of induction. The author quotes several cases from his practice which seem to him perfect examples of induction, such as that of a young woman who drank too much coffee and was miraculously cured by the advice to drink as much as she liked. Induction also underlies such phenomena as the slips of the tongue, ambivalence, the preference of men of dark complexion for blondes, love affairs of socially prominent people with their servants, the spirit of opposition, the resistance to new ideas, etc. In fact, everything that seems in contrast to the expected (i.e. expected by Dr. Ischlondsky) is due to induction. What in psychopathology is called conflict is the encounter of excitation and inhibition. Psycho-analytic treatment, in the author's view, aggravates the neurotic symptoms by reopening the fight against inadequate inhibition. ' It overthrows the inhibiting focus ' and restores the ' excitability of the cortical cell complex '. Repression is a manifestation of ' a lasting inhibition of a certain part of the cortex '. Induction does not occur if ' the primary nervous process ' is developed gradually. This is of fundamental importance for education and mental hygiene. Only the unprepared inhibition is harmful. The author dismisses the psychological approach to the study of human behaviour as purely speculative and subjective. But he naïvely claims that a mechanism which can be experimentally produced on the lowest level of integration determines behaviour on the highest level. Some chapters will make painful reading for neuro-physiologists; the author talks about centres and localization of behaviour pattern in a fashion which even half a century ago was dubbed ' brain mythology '. This book does not advance the understanding of the brain mechanisms underlying human behaviour.

E. Stengel.

Klinische Psychopathologie (Clinical Psychopathology). By Kurt Schneider. Third improved edition of *Beiträge zur Psychiatrie* (Contributions to Psychiatry). (Stuttgart: Georg Thieme Verlag, 1950. Pp. 179. Price DM. 11.40.)

This book is a collection of essays on problems of clinical psychiatry. They deal with the following subjects; classification and the concept of illness in psychiatry; psychopathic personalities; abnormal mental reactions; psychoses in mental defectives; organic psychoses; mental symptoms and psychiatric diagnosis; psychopathology of emotions and instincts. Professor Schneider has much to say on these subjects, on a descriptive level, that is sound and interesting. Psychodynamics have always been outside his province. As a book on psychopathology this is exceptional in that it does not even attempt a critical appraisal of the psycho-analytic contribu-

tion. Neither Freud nor any other psycho-analyst is mentioned. This is indeed ' psychopathology without tears '.

E. Stengel.

Rediscovery of Justice. By R. K. Bienenfeld. (London: George Allen and Unwin Ltd., 1947.)

R. K. Bienenfeld adds an entirely new field to applied psycho-analysis: that of jurisprudence in all its ramifications into public and private law. His book is a persistent and successful attempt at presenting social and legal conflicts in adult life as unconscious extensions of the conflicting situations in childhood. In the part dealing with ' Justice in the Nursery ' it is shown that the demands for justice presented to parents by brothers and sisters concerning their attitudes to each other are the model in society of the attitudes of fellow-men and citizens. The child in need will lean to the communistic demand for equality; if efficient, it will voice a socialist claim for reward according to achievement; if attacked, it will cling to the conservative protection of privilege; if attacking, it will arrogate the liberal principle of freedom of action; towards strangers it will adopt the nationalistic attitude of family pride. Likewise in relations between the subject and the government which is the domain of public law the infantile-parental relationship is regularly reproduced. In the initial stages of the nursery the child recognizes the divine right of the father to decide between right and wrong, and the same applies in primitive societies as to the divine right of the ruler. At the same time the child believes in his own omnipotence, which leads to an individualistic and anarchic tendency in society. His later acceptance of the reality principle leads to the modification of both tendencies into a wish for self-determination in order to master his own fate, and also to the conception of social co-operation by his desire to find his right place within the family. All these demands for justice as shown in the domain of private law, by the conceptions of communism, socialism, liberalism, conservatism and nationalism and in the domain of public law by the conceptions of theocracy, anarchic individualism, self-determination and social co-operation, are contradictory to each other, though every one of them is accompanied by a strong feeling for justice. Parental justice in the nursery will prevent the over-emphasis of any of these conflicting attitudes, just as efficient governments will have to mediate between the conflicting demands for equality, reward, privilege, etc. From this psychological point of view the legal systems of private and public law and their national and international institutions of procedure and enforcement are examined; the history of theocratic thought, individualism, self-determination and social co-operation is analysed and the possible future developments of political authority in the various European, American, and Asiatic societies are assessed. A minimum Bill of Human Rights is evolved on the evidence thus assembled. Dr. Bienenfeld's book proposes a new theory of relativity of Natural Law; just as the child evolves different concepts of government and relationships in earliest childhood and in his later social relations, so a primitive society will develop a sense of justice and institutions of law different from a more complex society. The concept of a Natural Law standing above human lawgiving is based on the psychology of the human mind, which has changed but little during the development of the human race. That is the reason why our sense of justice is mainly independent of the laws enforced in a given society. We have developed it in the early social conflicts of childhood which are forgotten, but still influence everyone's attitude to society.

A. Ehrenzweig.

Which Way Out. By C. P. Oberndorf, M.D. (New York: International Universities Press, Inc., 1948. Pp. 236, $3.25.)

Looking back over the now long record of psychoanalytical publications, it becomes apparent that the exposition of psycho-analysis, both in scientific and in popular aspects, has been hampered by what might be termed the comparative illiteracy of contributors. Granted that the literary standards of writers on general medicine are, to say the least of it, somewhat schoolboyish, one might nevertheless have expected those who are concerned with the mental problems and disorders of man to have some flair for descriptive writing. No doubt the exposition of unconscious function is peculiarly difficult; but this cannot fully explain why good popular accounts of psycho-analysis are so hard to come by or why scientific articles on the subject should pay less and less attention to the delineation in recognizable form of human character.

Dr. Oberndorf, as might have been expected of a psycho-analytical student of Oliver Wendell Holmes, has at the same time resuscitated some of the older and more cultured traditions of anamnesis, tried a not inexpert hand at character delineation in novel-form and broken new ground in the technique of popular presentation. The *leit-motif* of his book, or rather of his collection of short stories, is the development of psychiatry from its pre-Freudian phase down to post-war times. This is elaborated in a series of psychiatric vignettes sketched by the protagonist, one Dr. Ford, whose identity is not hard to seek. Current medical scepticism is voiced by a number of Dr. Ford's colleagues who act as a Columbian chorus of Dr. Watsons to his Sherlock Holmes. As the author indicates in a preliminary gloss, the object of the various stories is to illustrate some of the more important problems of depth psychology, indicating at the same time the interplay of unconscious and

pre-conscious motivations and on occasion underlining the rôle of constitutional and social factors in current conflict, all of which Dr. Oberndorf succeeds in doing almost without recourse to technical terminology, or, at any rate, using only such terms as can be comprehended on the run by any commonly-informed reader.

Although the more pedantic critics may object that only an impressionistic view of psychoanalysis can be achieved by these means, the fact remains that Dr. Oberndorf succeeds not only in capturing and holding the interest of his readers and in driving home without apparent effort the points he wishes to stress, but, a much more difficult task, in making his characters come to life. This is more than can be said of most popular outlines of psycho-analysis, to say nothing of the more hackneyed text-books on the subject in which clinical histories function more as classroom diagrams than as essays in portraiture. What emerges very clearly from this book is that the earlier psychiatric followers of Freud, amongst whom Dr. Oberndorf himself ranks deservedly high, based their clinical studies on what Dr. Brierley has recently described as a ' neo-realistic humanism '. Unlike many of their more formalistic colleagues they accepted the literal rather than the narrower professional meaning of the term ' psychiatry '. It is a thousand pities that under the modern, mechanistic and all-too-mechanized training of psycho-analytical students, this tradition is falling into decay. It is much to be desired that training curricula should include an obligatory course during which the student might come to realize that character-formation is one of the arts; and another, facultative course (obligatory, however, for research-students) during which he could be taught, if not indeed how to use the King's English, at least how to describe the conduct of human beings with understanding and in comprehensible terms.

Edward Glover.

Trends in Psycho-Analysis. By Marjorie Brierley. No. 39, The International Psycho-Analytical Library, edited by Ernest Jones. (London: Hogarth Press and the Institute of Psycho-Analysis, 1951. Pp. 320. Price 21*s*. net.)

For a long time psycho-analysts, following the lead of Freud himself, were content to carry on their work without much concern for the wider social, moral and philosophic issues raised by their discoveries. From various sides they were branded first as immoralists and later as reactionaries, but it is only in recent years that they themselves (perhaps not uninfluenced by that attitude of increasing social responsibility shown by scientists in some other fields) have manifested any considerable interest in problems of *Lebensanschauung*, in the contributions which psycho-analysis could make towards the alleviation of our social discontents, and in the general ethical background of psychoanalytic theory and practice. To a large extent Dr. Brierley's book can be considered as an addition to other recent attempts, such as those of Odier, Richard, Fromm, Money-Kyrle, Waddington *et al.*, Blanco White and the present reviewer, to place psycho-analysis in a larger social and ethical setting and thus to indicate its rôle in the general trend of contemporary thought and action.

The book is extraordinarily rich in its thought-provoking qualities; we can open it at almost any page and find thereon food for reflection and indications of lines along which further research and theory might profitably follow. Its clarity and orderliness are perhaps not quite on a par with its suggestiveness—and this is no doubt to some extent a consequence of the composition, for it is made up of revisions, elaborations and amalgamations of a number of articles which have appeared (with one exception) in this Journal between 1934 and 1947. Since there was some considerable overlap in the subject matter of the articles, there is admittedly and perhaps inevitably, a certain amount of repetition in the book and a return to the same themes in different contexts and from different approaches, a procedure which has its value as a thought-provoking device and as a restraint against oversimplification, but which has also its drawbacks from the point of view of systematic exposition. Fortunately readers of this journal will already be to a considerable extent familiar with the general trend of Dr. Brierley's contributions, and there is little doubt that they will welcome this bringing together of them in a revised and up-to-date form in which consideration is given to the work of a number of authors who have written since the original articles appeared.

After a useful synoptic introduction, the first two chapters contain, with only minor alterations, pre-war articles on ' Trends in Psycho-Analysis ' (a critical-historical review which originally appeared in *The British Journal of Medical Psychology* and which provides a somewhat inadequate and misleading title for the whole book) and ' Affects in Theory and Practice '. A third chapter (and here the revisions begin to be much more extensive) is devoted to ' Problems connected with the Work of Melanie Klein '. In this we are able to appreciate to the full Dr. Brierley's balanced and impartial approach, which regards Klein's contributions as highly stimulating and indicative of the vitality of psycho-analysis, but whose ultimate value can only be assessed after much further research leading to eventual modification or integration into the general body of psycho-analytic doctrine as the case may be. Among many valuable suggestions she points to the existence of certain factors which predispose to an unduly favourable or unfavourable attitude towards Klein's contributions. Thus, while ' people who make considerable use of introjection in maintaining their personal adaptation probably,

on the whole, feel more at home with concepts relating to "internalized objects"' (and may therefore accept Klein's 'hypotheses' too uncritically) 'those who habitually make greater use of projection mechanisms are likely to have more difficulty in appreciating that these objects are in any sense real'. A second group of difficulties is connected with the fact that recognition of 'internalized objects' 'contravenes the normal tendency of the ego towards synthesis' and may therefore appear as a threat to ego integrity. In this connection the author values highly Glover's view that a relatively synthesized ego is a result of a gradual integration of originally independent 'ego-nuclei' associated with different impulse-object systems—a view the formulation of which she regards as one of the beneficient indirect results of the stimulating effect of Klein's work. As regards more general criticism, she is inclined to think that some confusion has resulted from a failure to distinguish between what may be descriptively correct accounts of patients' experiences and their translation into a form appropriate and correct from the point of view of general scientific theory. Thus (to take a gross example) a patient with an over-acid stomach after eating a sour apple may be inclined to say 'the apple is burning a hole in my stomach'. The experience may indeed feel like that, but the real processes would be differently described by the physiologist; and, quite similarly, mental processes may have to undergo a corresponding change of expression before being incorporated into psychological theory. This distinction (which, Dr. Brierley suggests, has not always been adequately observed by Klein—or perhaps by her critics) leads to a wider and more thoroughgoing distinction between what are, in a later chapter, described as the personological and the metapsychological aspects of psycho-analytical theory.

The distinction in question must have a relation —which it would be interesting to consider in detail —to the 'idiographic' and 'nomothetic' disciplines as originally formulated, it would appear, by Windelband and adopted by G. W. Allport and others in relation to the study of personality. In Dr. Brierley's sense, personology in which we are primarily concerned with the individual patient, is appropriate to the consulting room, but metapsychology, which deals with mental life in general, is appropriate to the study; and the integration of psycho-analytic findings into the general body of science is dependent upon a satisfactory metapsychology. The importance of research and theory as well as of therapy should therefore, it is suggested, be emphasized in the training of students of psycho-analysis.

The final chapter, which is by far the longest, is devoted to 'Psycho-Analysis and Integrative Living', though its contents overlap to some extent with those of previous sections of the book. Like others before her, Dr. Brierley holds that the lesson of psycho-analysis for ethics lies in its emphasis on integration, and the kind of philosophy which she adumbrated might be described as Neo-Humanism or Neo-Realism, in which account is taken of the need for recognizing psychic reality (including infantile sexuality and aggression) as well as physical reality. Moreover, just as physical science starts from perception but soon passes from the naïve belief that external reality is in its essence just what it appears to be to our perceptive organs (which are highly selective and subject to the influence of distortion), so also psycho-analysis has taught us that we obtain only a very limited and biased view of psychic reality if we rely on simple introspection. The *inferences* made from psychoanalytic data must be admitted, just as in the case of inferences made from the data of external perception. Any sound ethics must come to terms with unconscious mental life, including the instincts, which ultimately provide 'the inspiration for living'.

In the course of her search for a framework for integrative living Dr. Brierley gives much consideration to the claims of religion, especially of Christianity, which, she considers, is for many years to come likely to exercise a bigger influence than many psychologists are inclined to believe. Christianity, it is suggested, caters better for a great variety of unconscious infantile wishes than does any other religion, and this position is supported by a most interesting treatment of Christian mysticism, the gist of which is perhaps a most succinctly expressed (among many other striking quotations) in the words of Nicholas of Cusa: 'Thou dost abide where speech, sight, hearing, taste, touch, reason, knowledge and comprehension merge in one.' Christianity seeks an integration of ego and super-ego based on a sublimation of libidinal impulses. Its weakness, as suggested, lies in dealing with these latter, which, in the absence of great powers of sublimation and aim-inhibition, are apt to evoke severe 'id vengeance' in one form or another. In virtue of the sublimation of love and the repression of aggression, Christianity also tends to foster excessive idealization, which, owing to the inevitably accompanying tendency to denigration, the author regards as one of the greatest menaces to balanced and realistic adjustment; a satisfactory neo-realistic attitude would overcome this infantile all-or-none reaction and would be able to tolerate a larger measure of ambivalence.

The reader may regret that no equal consideration is given to the promises and satisfactions offered by the modern political equivalents of religion. Indeed the argument in favour of Christianity might perhaps have been reinforced by the consideration that these latter, at least in the crude forms in which these have been mostly manifested, suffer in even greater degree from idealization and denigration. The obvious corrective for this in an attempted religion of Humanity (corresponding to

the attempted all-embracingness of Christianity) is dismissed somewhat cavalierly as 'mainly intellectual' and 'lacking in the profundity of emotional appeal characteristic of Christianity'. Dr. Brierley has clearly a poor opinion of the chances of such doctrines as that of 'Evolutionary Humanism', which under this or some somewhat similar name have been tentatively put forward as a basis for modern morals by a good many present-day intellectuals.

We have indicated here only a very brief selection of the problems touched on by Dr. Brierley in the course of her highly suggestive but somewhat discursive book, in which vista after vista is opened up but—as is perhaps inevitable when the territory envisaged is so wide—seldom explored to the end. This is a book upon which one could comment almost endlessly and in which every attentive reader (and the book does for the most part demand close attention) will find something to ponder, to criticize and to enjoy. It might perhaps have a bigger immediate influence, if it had been more systematically and concisely planned, but stimulation of thought rather than the delivery of any clear-cut message was obviously the main purpose of the author, who in this volume shows herself so full of tolerance and erudition. If approached by the reader in a corresponding spirit, the book may serve as a help to reflection and as a source of inspiration for many years to come.

J. C. Flugel.

ANNOUNCEMENTS

OF THE AMSTERDAM CONGRESS BUREAU

Registration. Sunday, August 5, 12 noon–5.0 p.m. All Congress members are requested to register in the Hall of the Royal Institute for the Tropics, Mauritskade 63, Amsterdam-Oost (tramway lines Nos. 9, 10 and 11), where they will receive their badges and Congress papers. Only badges give admittance to the Congress meetings and receptions. The meetings of the Congress are open to spouses of members, and the Congress fee of fl. 30 can be paid on registration day.

Final Dinner. Those who have booked for the final dinner or still wish to do so are requested to pay fl. 13 per person at the cashier's desk on registration day. (The dinner will take place in the Grand Hotel 'Gooiland' in Hilversum, where members will be taken in coaches from the Congress Hall via a very nice route along the river Vecht and the Loosdrecht Lakes.)

Tourist Office. Lissone-Lindeman's Tourist Agency who have looked to the hotel reservations will have an office in the Congress Hall. Here members can book for the excursions on Thursday afternoon and get all travel information. We wish to draw attention to the fact that in August the Amsterdam hotels are very fully booked so that in most cases it will not be possible for members to extend their stay at the last moment.

Money Exchange. The Rotterdamsche Bank will have a desk in the Congress Hall where money and travellers cheques can be exchanged.

Bookshop. There will be a bookshop in the Congress Hall where besides psycho-analytic literature books on Amsterdam and the Netherlands, on Dutch art and scenery and maps of Amsterdam and Netherland can be obtained.

Receptions. Members and their guests are invited to the reception by the Dutch Psychoanalytic Society on Sunday night, August 5, at 9.0 p.m. in the I.C.C. (International Cultureel Centrum), 'Vondelpark' Pavilion, Amsterdam (tramway lines Nos. 1, 2 and 3) and to the reception by the Burgomaster and Municipal Council of Amsterdam in the 'Rijksmuseum' (tramway lines Nos. 2, 3, 7 and 10) on Monday night, August 6. During this latter reception the collection of old Dutch Masters and the summer exhibition of Burgundian Art will be open. *No evening dress* at either reception or final dinner.

Interpreter. The French and English papers of the morning sessions and of one of the afternoon sections will be simultaneously interpreted by an English-French/French-English interpreter.

Excursions for guests. During the daytime morning and afternoon excursions will be organized for the guests of the Congress members.

ABSTRACTS

Gert Heilbrunn. 'Psychodynamic Aspects of Epilepsy.' *The Psychoanalytic Quarterly*, 1950, Vol. XIX, No. 2, p. 145.

Observations from the analysis of a group of five patients with idiopathic convulsive seizures led to the conclusion that passive dependence was the psychodynamic substratum from which secondary mechanisms emanated. The clinical psychopathological variations corresponded with the patient's early and later experiences and served as defences against, or as reactions to, the original dependence. The epilepsy appeared as a sign of physiologic disintegration of one or several impulses at a critical moment, when rising emotional tensions overwhelmed the available countercathexes, or when the waning forces of the ego offered too little resistance to the pressure of the repressed.

Clinical epileptic manifestations occurred only in the presence of pathological brain waves, whereas normal tracings were obtained from one patient who had suffered his last *grand mal* seizure eight years prior to analysis and who had remained free from any clinical epileptic symptoms ever since.

Author's Abstract.

Leon J. Saul. 'Physiological Systems and Emotional Development.' *The Psychoanalytic Quarterly*, 1950, Vol. XIX, No. 2, p. 158.

There are biological attachments and relationships to the mother other than the oral which are important psychologically and in the development of psychosomatic symptoms. Examples are the fœtal relation to the mother via respiration, through the skin, first intrauterine and then by fondling, and bathing; and the locomotor relationship through being carried by the mother. The rôle of these relationships in the formation of symptoms in the respective physiological systems is analogous to the rôle of oral sucking in gastrointestinal disorders. These organ systems are pathways for the satisfaction of needs and are points to which regression leads. Emotional conflicts may be expressed over preoral paths just as over the oral.

Author's Abstract.

Leon J. Saul. 'The Punishment Fits the Source.' *The Psychoanalytic Quarterly*, 1950, Vol. XIX, No. 2, p. 164.

According to the law of talion, 'the punishment fits the crime'. In addition to this an unconscious mental mechanism is often seen in which 'the punishment fits the *motive* for the crime'. This can be carried further to cases in which 'the punishment fits the *source of the motive*'. A person whose hostility is revenge for frustrated needs for love or for prestige punishes himself by frustrating these very needs. The central pathway may be an organ system, such as the gastrointestinal tract, or on a higher, more sublimated psychological level. Each person has, or tends to have, a particular pathway or combination of pathways for satisfying his needs over which his major emotional interplay is expressed—his frustrations, his fight-flight reactions and the reactions of his superego. This mechanism casts light upon various symptoms such as paranoid jealousy and castration anxiety and upon their choice.

Author's Abstract.

David Beres and Charles Brenner. 'Mental Reactions in Patients with Neurological Disease.' *The Psychoanalytic Quarterly*, 1950, Vol. XIX, No. 2, p. 170.

A study of the mental symptoms of nine hospitalized patients with various diseases of the nervous system indicated that the mental symptoms which they showed were related to the disability or suffering imposed upon them by their illnesses. It was concluded that one could best understand why such a disability was or was not psychologically traumatic (pathogenic) to any one patient in terms of the patient's unconscious conflicts. The illness was traumatic precisely because of the existence of such conflicts, even though at the time of the onset of the illness the conflict was symptomless.

It was Ferenczi's hypothesis that the first psychic consequence of physical illness was a withdrawal of libido from object relationships and a concentration of the increased narcissistic libido on the psychic representative of the diseased part. It is suggested that this should be reformulated to read, '. . . on the psychic representative of the part whose *function was disturbed*' regardless of the anatomic localization of the pathological process.

Author's Abstract.

Phyllis Greenacre. 'The Prepuberty Trauma in Girls.' *The Psychoanalytic Quarterly*, 1950, Vol. XIX, No. 3, pp. 298–317.

While the prepuberty period is generally one of the more silent areas of analytic investigation, a particular group of cases is exceptional in the appearance in this period of fateful traumata which were part of the presenting picture of the neuroses when the patients came for treatment. These

traumata were provoked by the victims, and were compulsive repetitions of precœdipal conflicts influencing the intensity of the œdipal phase and subsequent severity and deformation of the superego. These conclusions are drawn from the analyses of four patients.

The combination of the increased thrust of activity of the prepuberty years with increased sadomasochism derived from pregenital phases and a strong masculine identification during latency favours the occurrence of such traumata. There may, however, be a real element of fate as far as the child is concerned, which turns the significance of the experience one way or the other, depending upon the readiness to response of the person provoked or seduced to aggression. In all four cases the trauma involved experiences with adults: in three instances there were œdipal traumata, in one instance the re-enactment of a primal scene. The utilization of the trauma as a masochistic justification for a defence against sexuality was apparent and reinforced by its communication to others, and sometimes by its subsequent use for masochistic gratification. It is probable that the effect of the prepuberty trauma as a defence is dependent upon variable combinations of the degree of precœdipal sadomasochistic development combining with the severity of the later trauma, which is not wholly dependent upon the child herself. Traumata of an œdipal pattern are also more utilizable for defence than those occurring with other children, since the guilt can be the more readily shifted to the adult, and the child's own instigation of the trauma, together with the earlier events which have produced the pressure of provocation, more readily concealed.

Author's Abstract.

Otto E. Sperling. 'Interpretation of the Trauma as a Command.' *The Psychoanalytic Quarterly*, 1950, Vol. XIX, No. 3, p. 352.

The present theoretical approaches to the psychoanalytic understanding of war neurosis are insufficient. Freud's concept of the war neurosis does not explain the continuation of the neurosis after removal of the patient from the danger zone and his return to civilian life.

Based on the observation of many cases of war neurosis (with intensive analytic work on representatives from all of these groups), the author came to the conclusion that war neurosis is due to a conflict between love for and hatred of one's country, the heir to the œdipus relationship to father or mother, or both. A trauma is a stimulus, or an accumulation of stimuli, which breaks through 'the stimulus barrier'—the latter represented by the understanding of the stimulus. The emotional structure of the personality and previous experiences play a part in these interpretations and in the reaction to commands. In the same way as a body of suggested commands and standards can be established as a parasitic superego in hypnosis, so in the soldier and in the internees of concentration camps, the traumata may lead to an identification with the enemy and to an establishment of his commands and ideologies as a parasitic superego.

Author's Abstract.

Anne Freemantle. 'The Œdipal Legend in Christian Hagiology.' *The Psychoanalytic Quarterly*, 1950, Vol. XIX, No. 3, p. 408.

Jacobus de Voragine, the author of that medieval best-seller, *The Golden Legend*, briefly resumes there a generally accepted medieval legend: Judas came to Jesus initially to obtain forgiveness for having inadvertently murdered his father and married his mother. *The Golden Legend*, which appeared in 1260, contained a saint's life for every day in the year. The Judas story occurs under St. Matthias, February 24. Matthias, after the death of Judas, was chosen by the Apostolic college to succeed him.

Judas was supposedly the son of Reuben, of the tribe of Dan, and his wife, Giborea. One night after intercourse the latter dreamed she would bear a son who would be the downfall of her race. Nine months later to the day, a boy was born, and, as his parents did not wish to kill him, he was put into a basket and set on the Jordan river. The childless queen of an island called Iscariot found the baby, adopted him and later bore a son of her own. The foster-brothers were enemies, and Judas, learning of his adoption, killed the true son, fled to Jerusalem, and became the 'boy-friend' of Pontius Pilate. One day Pilate saw some apples from his window that he wanted, and Judas went to steal them for him. When the owner protested Judas killed him—his own father, of course. To quiet the widow, Pilate gave her to Judas for wife, and one night, weeping in her bed, she told Judas his story. Dream, basket, sea, foster brother, perversion, apples, and incest—the story really has everything!

Author's Abstract.

Herbert I. Harris. 'Repression as a Factor in Learning Theory.' *The Psychoanalytic Quarterly*, 1950, Vol. XIX, No. 3, p. 410.

In addition to the widely accepted factors of practice, reward and punishment, it is proposed that the learning process involves the efficient use of repression and repressive mechanisms. Repression can be considered a more complex form of the processes of suppression and inhibition.

Life activity is in essence an exchange of energy between the organism and its environment. Any repression of outpouring energy by the organism is of value to it only if greater mastery of the environment is thereby accomplished.

In autonomic nervous system impulses, repressive mechanisms appear to be employed constructively to accomplish maximal environmental mastery. Toilet rituals, constipation and emotional diarrhœas are all examples of the waste of emotional energy in which inefficient repressive as well as expressive mechanisms are involved.

Students who learn with difficulty often show similar patterns of inefficient repressive activity. In a large number of students under treatment, striking improvement in learning and habits of study has followed the expression of anger and resentment towards the parent in the permissive atmosphere provided by the psychiatrist, a father surrogate.

Author's Abstract.

Phyllis Greenacre. 'General Problems of Acting Out.' *The Psychoanalytic Quarterly*, 1950, Vol. XIX, No. 4, pp. 455–467.

The paper deals with habitual or frequent acting out. Agreeing with Fenichel as to the oral fixation and poor tolerance of frustrations, the heightened constitutional motility and the presence of severe early traumata (producing a repetitive abreactive acting out somewhat similar to that of the traumatic neurosis), the author considers in addition (1) a special emphasis on visual sensitization producing a bent for dramatization (derived naturally from the increased scoptophilia and exhibitionism) and (2) a largely unconscious belief in the magic of action, especially repetitive or imitative action. These factors are important in giving the cohesiveness to the fabric of phantasy and memory which is characteristic of neurotic acting out as distinguished from neurotic action. It is suggested that a common genetic situation in habitual actors-out lies in the very early disturbance in the developmental relation between speech and action, i.e. a condition of degradation of the functional utility value of speech, whether this be through speech being impaired or delayed in early childhood or to speech being encouraged for exhibitionistic and other narcissistic purposes rather than for communication, and especially for expression of emotion. Subsequently then these children act in order to communicate and talk to conceal rather than express their needs.

The latter part of the paper presents suggestions for management of habitual acting out in the analysis. Special emphasis is laid on early work with the patient's narcissism and with giving some understanding of the disturbed speech functioning, together with the (generally very difficult) analysis of those pieces of acting out which are reported in the analysis fairly early in the treatment. There are many cases which cannot be treated successfully.

Author's Abstract.

Mark Kanzer. 'The Œdipus Trilogy.' *The Psychoanalytic Quarterly*, 1950, Vol. XIX, No. 4, pp. 561–572.

The Œdipus Tyrannus of Sophocles is interpreted in terms of a neurosis precipitated in the father by the impending birth of a child. Regressing in phantasy to childhood curiosity and guilt over the mysteries of sex, the conflicts of an earlier phase of development are re-activated. The search initiated by King Œdipus into the causes of the plague that has befallen his native land (i.e. the mother-wife's pregnancy), can lead only to his own implication as once it had led to the discovery of the father's rôle. Now the resultant parricidal tendencies are turned against himself. Jocasta, the queen, is shown to be identical with the Sphinx; the entire drama is a portrayal of the legendary encounter between Œdipus and the fabled monster.

Variations of the same problem are to be found in the other plays of the trilogy, Antigone and Œdipus at Colonus. The repetitive theme is handled with increasing maturity by the successive heroes, however, apparently reflecting a successful working-through of the dramatist's phantasies. Aspects of the dramas in their relationship to various concepts of the Œdipus myth also receive attention.

Author's Abstract.

Géza Róheim. 'The Psychology of Patriotism.' *The American Imago*, 1950, Vol. 7, No. 2, pp. 3–19.

There is a great deal of evidence from mythology indicating that the earth, the geographical habitat of a people, is considered as the mother. The earth can be fertilized and is creative. In infantile phantasy patriotism, or love of country, represents love of the mother made possible by the repression of the primal scene knowledge and repression of any aggression directed to the mother. Patriotism is a variety of loyalty and love for the mother transformed into the Virgin Mary. The ego of the individual patriot is based to a great extent on introjection of good things (food, milk) received from a generous mother and also on the introjection of specific characteristic foods that serve both to give him national identification and to supply him with virility and strength: for example, British roast beef, Hungarian paprika. These various national foods are important indicators of the process of introjection of parental objects, an important part of character formation as well as of patriotism. Attitudes to King and country contain all the unconscious ambivalent feelings to father and mother.

Sidney Tarachow.

Howard F. Gloyne. 'Tarantism. Mass Hysterical Reaction to Spider Bite in the Middle Ages.' *The American Imago*, 1950, Vol. 7, No. 2, pp. 29–42.

A not uncommon phenomenon of the Middle Ages was tarantism, a disease caused by spider bite

and supposed to be cured by music. The disease was marked by great excitement, compulsive dancing, extreme emotionality, extravagant and licentious behaviour, sadomasochistic activity, rolling in filth and excessive drinking. The disease was somewhat contagious and chronically recurrent, especially in summer. It was known in Europe for over four hundred years, beginning in the fourteenth century. It is likely that this disease served as an outlet for the tendencies inherent in the suppressed orgiastic Dionysian rites. The behaviour of those afflicted offered an instinctual release, but consciously treated in a phobic fashion, as though provoked by the bite of the spider, and accompanied by great anxiety and compulsiveness. The group character of the symptomatic behaviour made the emotional and instinctual discharge easier to accomplish.

Sidney Tarachow.

Géza Róheim. 'Fire in the Dragon.' *The American Imago*, 1950, Vol. 7, No. 2, pp. 163–172.

The author quotes numerous myths all having one central theme: the hero is swallowed by an aquatic monster such as a dragon or whale. He lights a fire inside the monster, cuts out the heart and eats part of the creature, thus killing it, and escapes. The whale who thus supplies her body as food is the mother. The hero, on escape, often has the attributes of a newborn child, although his entry often has the characteristics of sexual phallic assault. The fire is coitus. Since a myth represents an anxiety situation and its solution, these myths represent the solution of the anxieties of the biting, eating child who is also sexually aggressive. The aggression is reversed: the mother swallows the child. The myth has at least a passive beginning.

Sidney Tarachow.

Leonard J. Duhl. 'The Effect of Baby Bottle Feedings on a Schizophrenic Patient.' *Bulletin of the Menninger Clinic*, 1951, Vol. 15, No. 1, pp. 21–25.

The case is briefly described of a 22-year-old man, a markedly regressed schizophrenic, who showed some improvement when fed with milk from a baby's bottle as an adjuvant to the ordinary hospital milieu programme. He returned to his previous apathetic state when the bottle feeding was discontinued, and again improved when it was resumed. The patient clearly remained grossly ill; the author claims that the progress that was made was due to the bottle feeding.

B. Joseph.

André Michel. 'Psycho-Analysis of Music.' *The Music Review*, November, 1950; extract from a book shortly to be published.

As music so far has not received much attention in the field of applied psycho-analysis, M. André Michel's attempt to relate musical expression to our psycho-analytical knowledge is to be welcomed. He mentions the various pre-genital instinctual sources behind the drive towards musical expression and discusses the complementary relationship between pre-genital fixation points and certain characteristics of the work of individual composers. This leads him to speak of oral (Chopin), anal (Stravinsky, Ravel) and phallic composers, the last being subdivided in two categories, viz. those whose work reflects a struggle to solve their œdipal conflicts (Debussy) and those who have actually accomplished this task (J. S. Bach).

Though it is not his intention definitively to reduce any composer to a specific category, such a correlation, based as it is on a qualitative appreciation of pre-genital drives, seems to us not to explain in what way the composer's fixation to a particular stage of libidinal development would account for the high level of satisfaction which a heterogenous audience derives from his music. One would suppose that fixation, by its very nature, is more likely to act as an impediment both to the creation of any true work of art and to the enjoyment of it by others. If, to quote one of the author's examples, Ravel's music were 'anal magic' it would meet with little response from those in whose libidinal make-up anality plays only a minor part. Conversely, genital characters would find a greater affinity with their own libidinal condition in Bach's fugues (in whose polyphonic style the author sees the musical expression of a capacity for a multi-object oblative relationship) than in the music of say, Mozart (who had many infantile character traits); an assumption which lacks foundation. In the case of Mozart it is of special interest to note that it was only as a musician he was able to reach maturity, and that at an unusually early age and to an astonishing degree. It remains, none the less—a fact which would apply to any work of art—that component instincts and early object relationships can be traced in musical creation. This is shown with the aid of some very interesting examples taken from Debussy's score of Maeterlinck's *Pelléas et Mélisande*. The author also shows that musical and rhythmical expression allows of a greater subtlety of dramatic representation—e.g. by the use of a theme or part of a theme as a means of alluding to an affective state or to a person or situation giving rise to it—than words can convey. This strikes us as the best and most convincing part of the paper. The author's contention that through the medium of music there becomes possible the conscious rendering of thought which cannot be expressed verbally, is, however, open to criticism. The word 'conscious' here can be meant only in its descriptive sense, and if we understand the author's meaning, he would like to equate tone-cathexis with word-cathexis as alternative psychic paths both leading to conscious thought expression. The fallacy may well lie in confusing what is conscious in the musical creation with what is its latent counterpart. A striking

feature of the technique employed in musical composition is its resemblance to that of dream formation and wit. In the art of the composer we find abundant use of the same devices as are employed in the dream work: condensation, displacement, turning into its opposite, omission, etc. Michel seems also to have this similarity in mind: 'Most musical thoughts are unthinkable in words. Moreover, several musical thoughts superimpose themselves at various levels of the psyche and the language of words is able to express but one at a time. If it had to compensate for this inability by necessarily successive explanations, the least of the words would be burdened with an intolerable dull commentary, which a few notes of music would easily replace.' However, if a psychic equivalent for musical thought has to be found among other modes of ideational expression, and comparisons made, the search would have to be made in the direction of the manifest dream content rather than in the sphere of conceptual thought processes.

The substitution of verbal language for musical language which the author recommends as a means of communication in the analysis of musicians as a means of reaching a deeper understanding of their art can have at most a strong romantic appeal.

C. D. Gomperts.

John Rickman. 'The Development of Psychological Medicine.' *British Medical Journal*, 1950, No. 1.

This is the psycho-analyst's contribution to a series of articles designed to cover the development of medical theory and practice between 1900 and 1950. It can be said of psychodynamic ideas that they have given a new dimension to medical thought, and this is especially true of psychiatry. The key idea to this great advance in medical theory and practice was published just fifty years ago by Freud in his *Interpretation of Dreams*. 'A clinician, without laboratory aids or other such devices, by the closest attention to the material before him, unpromising and the least worthy of scientific care as it was then thought, changed his speciality out of recognition and raised the potential of every doctor's clinical interview.'

W. H.

Sir David K. Henderson. 'Reflections on Criminal Conduct and its Treatment.' *British Medical Journal*, 1950, No. 4674, p. 311 (August 5, 1950).

This article is the Memorandum submitted by Professor Henderson to the Royal Commission on Capital Punishment. In his introduction the author refers to the larger problem of 'the sick society in our midst' which calls for the improvement of genetic, social and economic conditions. Punishment should be considered in relation to these problems as well as to the medical factors. The violent methods of punishment have little or no constructive value. Legal and public opinion, however, is apt to adopt a moralistic rather than a medical code and to be sceptical of the findings of the psychiatrist; in consequence, medical opinion should be stated in terms which can be easily understood and should deal with the actual facts. The great difficulties are that the symptoms are so often entirely subjective, and that we cannot, except rarely, point to any one specific causation as in the case of physical illness. The legal outlook is too greatly dominated by the concept of reason and free will, and by lack of appreciation of the fact that conduct is motivated by instinctive drives which operate at a much less conscious level. On the other hand, it may be argued that the medical point of view is too liberal-minded, concerns itself too greatly with the individual. Yet only individualization, the dominant truth of modern medical science, allows a more hopeful prospect in the future. The large army of recidivists is the best answer to the arbitrary-sentence method at present in vogue.

These general statements are then applied to the main groups of mental, nervous and character disorder. In the author's opinion, the plea of mental disorder is submitted too frequently in cases involving a capital charge, really as a plea *ad misericordiam*. In less serious cases the plea of mental disorder is not submitted often enough, largely because the accused prefers a definite prison sentence to prolonged treatment in a mental hospital. As regards the McNaughten Rules, which are no longer in harmony with medical knowledge, the author suggests that, instead of polishing them up or introducing other rules, they should be dispensed with altogether. Every case should be judged on its individual merits rather than in terms of a formula. A psychiatric examination is advised in every case involving capital punishment. For those persons adjudged as of unsound mind the author advocates care and treatment in a special type of mental hospital independent of a prison régime or, failing this, in a modern psychiatric department within the prison system; more frequent use of parole and transfer to civil hospitals.

The law's refusal to allow Mental Deficiency (except in the most gross cases) to be a defence in bar of trial or sentence is deplored. This should apply to mental deficiency of whatsoever degree, and mentally defective criminals should be cared for under hospital or colony conditions until they can be discharged with safety to the public.

The Psychopathic States are considered the most serious and most controversial medico-legal and social problem. The more serious cases are not sane enough to be at large and not insane enough to be certifiable. The author agrees with the practice of the Scottish courts, which have generally

accepted the doctrine of limited or modified responsibility in murder cases, and recommends its application to a wider range of cases, e.g. assault, sexual offences, etc. He pleads for an indeterminate sentence until a sense of social responsibility is established, as well as care in a special institution or colony such as has been established in Denmark at Herstedvester (outlined in the Appendix).

With regard to the Psychoneurotics, the author stresses the importance of understanding the unconscious determination of their conduct disorder. While he has never known a pure obsessive-compulsive state lead to a homicidal attack, sexual offences are common. Although unwilling to go so far as to say that all criminal acts must be caused by inner conflicts, he considers that the conflict which produces criminal acts in the case of delinquents is very much the same in type as that which produces neuroses. The reaction is different, depending on the personality structure.

In conclusion, the author pleads for increased understanding and co-operation between the legal and medical professions; good psychiatric units where satisfactory examination and observation can be carried out previous to trial, and where suitable cases can have adequate treatment after trial; an efficient after-care organization; a judiciary imbued with a remedial outlook and able to think in terms of illness which may be entirely subjective; modesty on the part of the psychiatrist in relation to his ability to attain cures in the case of so seriously disturbed individuals.

L. H. Rubinstein.

Hedwig Schwarz. 'Dorothy: The Psycho-Analysis of a Case of Stealing.' *The British Journal of Delinquency*, 1950, **1**, p. 29.

The case described is that of a girl of nineteen, treated for the I.S.T.D. (Institute for the Scientific Treatment of Delinquency) from March, 1945, until April, 1946. The case was selected for the purpose of determining whether the standard analytic technique can be used successfully in certain types of delinquency. The girl had been committed to Sessions for a Borstal sentence, but had been given another chance (her third) on probation, on condition of six months' training at a hostel. This period, during which she could attend once a week only, was used as an introductory phase to prepare her for the idea of treatment and to confirm her suitability for psycho-analysis proper. Her strong wish to return to her mother was used to gain her co-operation in coming for four sessions a week, after her discharge from the probation hostel and a job in the vicinity of the consulting room had been secured through the Probation Officer's help. It was felt that such resort to unorthodox methods was necessary in the case of a delinquent who is like a child as regards insight, therapeutic drive and general personality structure (weak ego and super-ego).

She had grown up in poor circumstances, as the only girl with two elder and two younger brothers; the father was a permanent war-invalid, the mother the bread-winner. Before his death, on her seventeenth birthday, the father earned some money and spent most of it on presents for her. A younger brother was killed in an air-raid. Her earliest memory of stealing revealed the main conflict, jealousy of and rivalry with mother: theft of a doll at the age of about five when the youngest brother was born. Marked sense of guilt for her aggressive behaviour to brothers and other small children. Tendency to hide deafness in one ear, which was taken as punishment for early masturbation. Constant conflict between her feminine and masculine wishes; competition with boys and later taking father's place in relation to mother. Stealing in a compulsive manner, invariably from women in superior or enviable positions, and with marked signs of wish for punishment. The last stood also for sexual gratification of partly exhibitionistic, partly masochistic type.

The hysterical fears of a passive (feminine) situation and of identification with her mother were analysed in great detail. Her previous resistance to boy friends gave way to a stable relationship; but this improvement opened the route of escape into marriage away from London, with adoption of the mother-in-law as the good mother and desertion of the mother as well as of the analyst. This acting-out of the conflict with mother and of the negative transference before they could be satisfactorily analysed is an example of the main difficulty in the treatment of this case and of delinquents in general. The author's conclusion is that, while this analysis proved once more the possibility of understanding delinquents psycho-analytically and of greatly improving their conduct, skill in analysing delinquents will lie in the analyst's capacity to foresee the likelihood of their acting-out, to forestall it if possible or, at least, to predict it to the patient, or even, as Aichhorn did, to provoke such acting-out in certain cases and to lead the delinquent to certain dramatic emotional upheavals in the transference situation.

L. H. Rubinstein.

Frederick C. Redlich, John Dollard, Richard Newman. 'High Fidelity Recordings of Psychotherapeutic Interviews.' *American J. of Psychiatry*, July, 1950, **107**, No. 1, pp. 42–48.

The authors state with unrestrained surprise that most psychiatric patients easily accept the technique of interview recording while psychiatrists reject it initially, until shown that most of the objections are rationalizations. The great deal of screening that usually takes place in case demonstrations, often totally changing the character of the reported interview, is not possible with electric recording. The beginner in psychotherapy usually

has feelings of insecurity, anxiety and guilt about this activity, and even the experienced therapist is not eager to have his method recorded faithfully and in detail. In this respect teaching in psychiatry differs markedly from any other clinical speciality. Recording offers the additional advantage of giving the student an opportunity to observe the teacher. This could eliminate a certain infantilism of the parent-teacher watching exclusively the student infant who never has a chance to reverse the procedure. According to the authors' experience, high fidelity recording of psychotherapeutic interviews is an advisable new technique in teaching.—The author has failed to mention the peculiar phenomenon of paralysing boredom which spreads over a group of students when listening to the recordings played to them.

Martin Grotjahn.

Illert, W. ' The Change of Symptoms in G.P.I.' (*Über den Symptomwandel der paralytischen Psychose*). *Fortschritter der Neurologie und Psychiatrie*, 1950, Part 1.

The paper deals with a phenomenon which has some resemblance to the change of symptoms in hysteria. The material is based on a statistical analysis of the records of Heidelberg Psychiatric Clinic. The expansive form was the most common form of G.P.I. in 1892 (46 per cent. in 1892, 9 per cent. in 1942), while simple dementia is the most common form in 1942 (77 per cent. in 1942, 32 per cent. in 1892). The change is statistically significant, but no explanation is offered.

H. A. Thorner.

Asenath Petrie. ' Personality Changes after Pre-Frontal Leucotomy.' *Brit. J. Med. Psychol.*, 1949, **22,** Parts 3–4.

This is the second of two papers, each of which is a report on the changes in their performances on certain psychological tests of twenty patients who had undergone leucotomy. These patients are described as ' displaying depressed, anxious or obsessional features '. No further clinical description or valuation is given, and the report is in terms of behavioural performances on the tests. The patients were tested before leucotomy and three months and nine months after the operation. The first paper dealt with the results after three months; this deals with results after nine months. About ten tests altogether were used. Mainly, however, two sets were employed: (*a*) Tests of Intelligence: the Wechsler Scale, the Porteous Mazes and part of the Stanford-Binet Test. (*b*) Tests of ' Neuroticism ': Body Sway (Suggestibility), the Track Tracer (level of aspiration and work curve). Other tests included also tests of physical endurance, of concentration, of attitudes to illness, of response to jokes. All these tests are often used as aids in differentiating between neurotics and normals. The only changes reported are those which were statistically significant. Results showed (1) that, on the whole, there was a drop in I.Q. as measured by the Wechsler Test—the drop being due to a significantly lower performance on the verbal sub-tests; (2) an improvement of the ability to generalize correctly; (3) greater difficulty in dealing with social concepts; (4) some loss of ability to learn from errors. Furthermore, patients (*a*) became less persistent at their tasks; (*b*) tended to concentrate on speed rather than accuracy (e.g. on the Track Tracer); (*c*) showed less suggestibility (as measured by the Body Sway test); (*d*) were more realistic in their level of aspiration for a particular task. There was also included a test designed to measure the ' tendency to self-blame '—in this case, specifically, the tendency to ascribe undesirable traits to oneself. This tendency, which had already diminished three months after leucotomy, had diminished further after nine months. The general conclusions show that ' measures associated with neuroticism ' (Eysenck) had decreased, and that performance intelligence scores had slightly increased.

J. Hopkins.

K. R. Eissler. ' The Chicago Institute of Psychoanalysis and the Sixth Period of the Development of Psychoanalytic Technique.' *J. General Psychology*, 1950, **42,** 103–157.

This is a critical analysis of the theories and methods of treatment of the ' Chicago School ' as described in *Psychoanalytic Therapy: Principles and Application* by Alexander, French and others. Their deviations in theory and technique from those of Freudian analysis are described in some detail.

The Chicago theories cannot rank as a stage in the development of the classical tradition of psychoanalysis; this ' sixth period ' shows little sign of organic derivation from the previous line of analytic development. The main thesis is that Alexander and French's methods are not in any real sense psycho-analytic, although described as such.

Alexander's definition of neurosis is superficial, nearer in type to Adler's conceptions than Freud's: his views regarding the origin of neurosis are not validly derived, since he discounts the importance of infantile traumata and leaves the genesis of the neurosis unexamined. His theory of transference and resistance approximates to the Adlerian concepts—neurotic withdrawal from difficult life-situation and resort to infantile fantasy gratification.

They claim to have a new technique for the handling of transference and regret the inordinate length of psycho-analytic treatment, which they attribute in part to the faulty handling of transference. Eissler criticizes the remedies they propose for handling this problem.

Regarding the results of their treatment, even in their own descriptions of their therapeutic achieve-

ments, their patients do not seem to have made any progress in their capacity to test psychic reality, although the façade of their personalities may be considerably changed.

The aim of psycho-analysis is a structural change. The type of clinical improvement achieved by Alexander and French's methods, and named by them psycho-analysis, says Eissler, represents nothing more than a change of content. The authors have 'not reported one instance of structural change' and therefore should not call their book 'Psychoanalytic Therapy'.

The discussion of this section is detailed and very interesting in illustrating how deviations from analytic practice in the interests of shortening the treatment period materially alter the efficacy of the treatment.

Alexander's position in 1949 is in some respects very near to Freud's position of 1900, i.e. prior to the introduction of the structural aspect into psycho-analysis.

The type of treatment in which Alexander shows his greatest success is that which effects an anxiety-relieving adjustment in personality with consequent real gains in general competence, but Eissler emphasizes that this treatment is in no sense psycho-analysis and that the 'new' technique has mis-adapted some elements of psycho-analytic technique in the service of a relatively superficial psycho-therapy.

The lack of wisdom on the part of the authors in taking their patients' reports at their face value is criticized, also their advice on planning treatment.

Some possible sociological and personal explanations for the desire shown by certain analytic groups to find methods of shortening treatment time are mentioned.

M. Brady.

NEWS, NOTES AND COMMENTS

17th International Psycho-Analytical Congress, Amsterdam, August 5–9, 1951. The Scientific Programme of the Congress will include approximately thirty-five papers read by individual members. These, as usual, come from rather wide sources—Berlin, Japan, Jerusalem, London, Paris, Prague, Stockholm, Vienna, Zurich, Baltimore, Boston, Cleveland, Detroit, New York, Philadelphia, Los Angeles, San Francisco. Two Symposia have now definitely been arranged: (1) *Mutual Influences in the Development of Ego and Id.* Dr. W. Hoffer (London) and Dr. Heinz Hartmann (New York) will open the Symposium and the following will contribute as discussants: Miss Anna Freud (London), Dr. Edward Bibring (Boston), Mrs. Melanie Klein (London), Dr. Sacha Nacht (Paris), Dr. Herman Nunberg (New York), Dr. W. Clifford M. Scott (London), Dr. H. G. van der Waals (Amsterdam); (2) *Re-evaluation of the Rôle of the Œdipus Complex.* Dr. Jeanne Lampl-de Groot (Amsterdam), Dr. Paula Heimann (London) and Dr. H. A. van der Sterren (Amsterdam) will introduce the subject and the discussion will be open to members from the floor.

25th Anniversary of the Opening of the London Clinic of Psycho-Analysis and of the Institute of Psycho-Analysis' premises at 96 Gloucester Place, W.1. The opening of the Clinic took place on May 6, 1926, on the occasion of Professor Sigmund Freud's seventieth birthday. To celebrate the 25th Anniversary, over 140 members and students met in the Institute's rooms at 96 Gloucester Place, W.1, on May 7. In their speeches, the President, Dr. William H. Gillespie, Dr. Ernest Jones and Dr. John Rickman recalled the major phases through which psycho-analysis had passed in this country during this period. They expressed their hopes and wishes for its continued progress in a new building recently purchased by the Institute. These much larger quarters will be occupied during the autumn. The Clinic's Director, Dr. W. Clifford M. Scott, will then be in a position to accommodate an increasing number of staff and patients. The need for more space has, throughout the post-war period, been equally felt by the Committee organizing the training of students.

Appeal Fund—Institute and Clinic of Psycho-Analysis, London. The Institute of Psycho-Analysis is launching an appeal for funds and hopes to raise £100,000 or an income of £3,000 a year. Recently, a new building, Mansfield House, New Cavendish Street, W.1, had to be bought, and while the Institute's funds have just met the purchase cost, money is needed to maintain the premises and to expand the teaching and clinic work. It has no support from public funds, though the Clinic receives an annual grant from the Regional Hospital Board (for psycho-analytic treatment of patients but not for the training of students).

The Institute was incorporated in 1924. Its main activities have been the training of psycho-analysts (about sixty are in training now) and the maintenance of a Clinic, which now has a staff of ninety and which treats both adult and child patients without payment to the psycho-analyst and with only such payment from the patient as he is thought able to make.

The appeal is signed by Dr. J. C. Flugel, Dr. William Gillespie (chairman), Dr. Ernest Jones, Professor L. S. Penrose, Professor Sir Arthur Tansley and Professor F. R. Winton. Communications (Donations, requests for the Appeal) should be addressed to the Secretary, Institute of Psycho-Analysis, 96 Gloucester Place, London, W.1.

BULLETIN OF THE INTERNATIONAL PSYCHO-ANALYTICAL ASSOCIATION

EDITED BY
GRETE L. BIBRING, M.D., GENERAL SECRETARY

I. *REPORTS ON TRAINING ACTIVITIES*

AMERICAN PSYCHOANALYTIC ASSOCIATION

Members of the Board on Professional Standards, 1949–50*:*

Dr. Robert P. Knight (Chairman), Dr. Ernest E. Hadley (Secretary). Boston Psychoanalytic Institute, Drs. Edward Bibring, John M. Murray; Chicago Institute for Psychoanalysis, Drs. Franz Alexander, Therese F. Benedek; Detroit Institute for Psychoanalysis, Drs. Leo H. Bartemeier, Richard F. Sterba; Los Angeles Institute for Psychoanalysis, Drs. Ernst Lewy, May E. Romm; New York Psychoanalytic Institute, Drs. Sara A. Bonnett, Sandor Lorand; Philadelphia Psychoanalytic Institute, Drs. G. Henry Katz, George W. Smeltz; San Francisco Institute for Psychoanalysis, Drs. William G. Barrett, Emanuel Windholz; Psychoanalytic Clinic for Training and Research, New York, Drs. George E. Daniels, Abram Kardiner; Topeka Institute for Psychoanalysis, Drs. Karl A. Menninger, W. C. Menninger; Washington-Baltimore Psychoanalytic Institute, Drs. Ernest E. Hadley, Edith Weigert. *Ex officio:* Dr. M. Ralph Kaufman (President, Am. PA.A.), Dr. LeRoy M. A. Maeder (Secretary).

Members of the Board on Professional Standards, 1950–51*:*

Dr. Robert P. Knight (Chairman), Dr. Ernest E. Hadley (Secretary). Boston Psychoanalytic Institute, Drs. Edward Bibring, John M. Murray; Chicago Institute for Psychoanalysis, Drs. Franz Alexander, Therese Benedek; Detroit Institute for Psychoanalysis, Drs. Leo H. Bartemeier, Richard F. Sterba; Los Angeles Institute for Psychoanalysis, Drs. Ernst Lewy, May E. Romm; New York Psychoanalytic Institute, Drs. Sara A. Bonnett, Sandor Lorand; Philadelphia Psychoanalytic Institute, Drs. O. Spurgeon English, Leon J. Saul; San Francisco Psychoanalytic Institute, Drs. D. A. Macfarlane, Bernhard Berliner; Psychoanalytic Clinic for Training and Research, New York, Drs. George E. Daniels, Abram Kardiner; Topeka Institute for Psychoanalysis, Drs. Karl A. Menninger, Jan Frank; Washington-Baltimore Psychoanalytic Institute, Drs. Ernest E. Hadley, Sarah S. Tower. *Ex officio:* Dr. M. Ralph Kaufman (President, Am. PA.A.), Dr. LeRoy M. A. Maeder (Secretary).

BOSTON PSYCHOANALYTIC INSTITUTE

Educational Committee: Dr. Bernard Bandler (Chairman), Drs. Edward Bibring, Grete L. Bibring, Felix Deutsch, Helene Deutsch, Ives Hendrick, John M. Murray (*ex officio*), Eleanor Pavenstedt (Secretary), Mrs. Beata Rank.

Training Analysts: Drs. Bernard Bandler, Edward Bibring, Leolia A. Dalrymple, Julia Deming, Felix Deutsch, Helene Deutsch, Ives Hendrick, Edward Hitschmann, Lucie Jessner, Joseph J. Michaels, John M. Murray, Helen H. Tartakoff, Mrs. Beata Rank, Dr. Lydia G. Dawes (Supervisory Analyst for Child Analysis).

Programme of Courses, 1949–50*:* Child Development [1] (M. Putnam and others); Clinical Conference and Case Discussion and Technique (L. Berman and I. Hendrick); Group Control (G. L. Bibring); Child Analysis (Dr. Lucie Jessner and Mrs. Beata Rank); Introduction to Psychoanalysis, Theory of the Instincts, Ego Psychology (E. Bibring); Psychoanalytic Psychiatry (J. M. Murray); Psychoanalytic Psychotherapy (F. Deutsch); Interpretation of Dreams (J. Deming); Freud's Papers (B. Bandler and J. J. Michaels).

Seminars for Social Workers, 1949–50*:* Introduction to Psychological Problems of Case Work (Louis S. Chase); General Psychological Problems of Case Work (Elvin V. Semrad); General Psychological Problems of Case Work (Helen H. Tartakoff); Problems of Supervision (Leo Berman).

CHICAGO INSTITUTE FOR PSYCHOANALYSIS

The Chicago Institute for Psychoanalysis is an autonomous organization and its training activities are not a function of the Chicago Psychoanalytic Society.

A teaching staff of 23 physicians, 19 of whom are recognized training analysts in the Chicago Psychoanalytic Society, functions as its own training committee and carries on all functions of selecting and training students. It has a Committee on Membership and Education, composed in 1949–50 of the following: Drs. Therese Benedek; Roy Grinker; Bernard Kamm; Edwin Eisler; George Wilson—all of whom are training analysts in the Chicago Psychoanalytic Society.

Training Analysts: Drs. Franz Alexander, Catherine Bacon, Therese Benedek, N. Lionel Blitzsten, Ludolf Bollmeier, Hugh Carmichael,

[1] Obligatory for first-year students; all other courses obligatory for all students.

Edwin Eisler, Thomas French, Minna Emch, Margaret Gerard, Maxwell Gitelson, Roy Grinker, Bernard Kamm, Harry Lee, Maurice Levine, Adelaide Johnson, Paul Kramer, Helen McLean, Fritz Moellenhoff, George Mohr, Emmy Sylvester, Milton Rosenbaum, Lucia Tower, Edoardo Weiss, George Wilson, Albrecht Meyer.

Programme of courses. First Year: Psychopathological Demonstrations (A–1, 2 quarters); Psychopathological Demonstrations (A–2, 3 quarters); Diagnostic Interview (A–3, 2 quarters); Clinical Conferences (B–1, 3 quarters); Fundamentals of Psychodynamics (C–1, 2 quarters); Development of Personality: Infancy and Childhood (C–2a, 2 quarters); Development of Personality: Adolescence (C–2b, 1 quarter). *Second Year:* Clinical Conferences (B–2, 3 quarters); Maturity and Senescence (C–2, 1 quarter); The Neuroses (D–1, 1 quarter); Behaviour Disorders, Perversions, Psychoses (D–2, 1 quarter); Freud's Case Histories (D–4, 1 quarter); Theory and Practice of Dream Interpretation (E–1a, 3 quarters); Freud's Interpretation of Dreams (E–1b, 1 quarter); Psychoanalytic Theories of the Drives (E–2, 2 quarters); Review of Literature on Psychoanalytic Technique (F–2, 1 quarter); Supervised Analyses (F–5, 3 quarters); Seminars on Classical Psychoanalytic Literature (G–1, 3 quarters). *Third Year:* Advanced Clinical Conferences (B–3, 3 quarters); Clinical Conferences on Children (B–4, 3 quarters); Freud's Metapsychological Papers (E–3, 1 quarter); Systematic Analysis of the Integrative Functions (E–4a, 2 quarters); Clinical Study of the Integrative Functions (E–4a, 2 quarters); Technique of Child Analysis (F–3, 1 quarter); Ego Analysis as a Guide to Therapy (F–4, 1 quarter); Supervised Analyses (F–5, 3 quarters); Seminars on Current Psychoanalytic Literature (G–2, 3 quarters).

DETROIT PSYCHOANALYTIC INSTITUTE

The Training Committee of the Detroit Psychoanalytic Institute is comprised of the training analysts of that Institute: Drs. Leo H. Bartemeier, Maurits Katan, Anny Katan, Richard F. Sterba, Editha Sterba.

Candidates in training in September, 1950: 20.

Programme of courses: Bi-weekly Lectures on Ego Psychology (Fritz Redl); Bi-weekly Lectures on Child Psychology (Editha Sterba); Seminar on Freud's Writings (Richard Sterba); Weekly Seminar on Psychoses (Leo H. Bartemeier); Bi-weekly Clinical Seminar (Leo H. Bartemeier); Weekly Seminar on Psychoanalytic Technique (Case Seminar).

LOS ANGELES PSYCHOANALYTIC INSTITUTE

1950

The Los Angeles Psychoanalytic Institute serves both the Los Angeles Psychoanalytic Society and the Society for Psychoanalytic Medicine of Southern California, but each organization has its separate programme of courses, pending the approval of the American Psychoanalytic Association for a separate Institute for the Los Angeles Psychoanalytic Society.

Each of the Societies has its separate educational committee which together constitute an executive committee for the Institute, consisting of seven training analysts. All recognized candidates of the institute have free choice between the two programmes of courses offered by the institute.

Candidates in training as of June, 1950: 57.

Training Analysts. For the Los Angeles Society: Drs. Carel van der Heide, Charles W. Tidd, Ernst Lewy, Ralph R. Greenson, Mrs. Frances Deri, David Brunswick, Ph.D.

For the Society of Psychoanalytic Medicine of Southern California: Drs. Norman Levy, Martin Grotjahn, Milton L. Miller, May E. Romm.

Programme of Courses. Offered by the Los Angeles Psychoanalytic Society through the Institute: *Fall Trimester:* Basic Concepts of Psychoanalysis (H. Fenichel); Freud's Writings (R. Newhouse); Development of the Personality, Pt. I (I. McGuire); Theory of Neurosis (Carel van der Heide); Theory of Instincts (D. Brunswick); Clinical Conferences, Dream Presentations (F. Deri); Dynamics of the Perversions (H. Fenichel); Clinical Conferences (R. R. Greenson); Classic Literature other than Freud (I. McGuire); Freud's Writings (L. Rahman); Dynamics of the Psychoses (L. Rahman); Current Literature (C. van der Heide).

Offered by the Society for Psychoanalytic Medicine of Southern California through the Institute: *Fall Trimester:* Psychotherapy Seminar (M. Grotjahn); Freud's Writings—Psychopathology of Everyday Life and Wit and its Relation to the Unconscious (A. A. Clinco); Selective Reading from Freud's Writings (G. Frumkes); Freud's Writings—Case Histories (F. J. Hacker); Theory and Practice of Child Analysis (Marie Briehl); Classic Literature other than Freud (Walter Briehl); Clinical Conferences, Special Problems and their relation to Current Psychoanalytic Literature (M. Grotjahn); Theory of Instincts (E. Levy); Freud's Writings, *Collected Papers*, Vol. V (J. Marmor); Clinical Conferences, Continued Case Demonstrations (M. L. Miller); Clinical Conferences with special regard to Female Psychology (May E. Romm).

NEW YORK PSYCHOANALYTIC SOCIETY

1949–50

Educational Committee: Dr. Sara A. Bonnett (Chairman); Drs. Arnold Eisendorfer, Phyllis Greenacre, Heinz Hartmann (*ex officio*), Mary O'Neil Hawkins, Otto Isakower, Edith Jacobson, Robert P. Knight, Marianne Kris, Edward Kronold, Rudolf M. Loewenstein (*ex officio*), Ruth Loveland, Lillian Malcove (*ex officio*), Herman Nunberg, Annie Reich, Marcus Schatner.

Training Analysts of the New York Psychoanalytic Society:

Instructor Emeritus: Dr. Adolph Stern. *Instructors* (appointed triennially): Drs. Samuel Atkin, Robert C. Bak, William K. Bluhm, Sara A. Bonnett, Henry A. Bunker, Franz S. Cohn, Raymond de Saussure, Arnold Eisendorfer, Kurt R. Eissler, Ruth Eissler, Elisabeth R. Geleerd, P. Goolker, Raymond Gosselin, Phyllis Greenacre, Susanna S. Haigh, Fanny von Hann-Kende, Heinz Hartmann, Mary O'Neil Hawkins, Otto Isakower, Salomea Isakower, Edith Jacobson, Ludwig Jekels, Sidney Kahr, Sylvan Keiser, Robert P. Knight, Marianne Kris, Edward Kronold, Lawrence S. Kubie, Philip R. Lehrman, Bertram D. Lewin, Rudolph M. Lowenstein, Sandor Lorand, Ruth Loveland, Henry Lowenfeld, Margaret S. Mahler, Lillian Malcove, William Needles, Herman Nunberg, Annie Reich, Marcus Schatner, Herman Schlionsky, René A. Spitz, Emile Gordon Stoloff, Leo Stone, Bettina Warburg, Frederic S. Weil. *Lecturers* (appointed annually): Drs. Charles Davison, Ludwig Eidelberg, Robert Fliess, Geza Roheim, Ph.D.

Candidates in training in November, 1950: 138 Registered Students; 7 Research Students.

Programme of Courses. First Year. First trimester: Theory of Instincts (G. Gero); Reading Seminar (F. S. Weil); General Introduction to Psychoanalysis (R. de Saussure); Psychology and Pathology of Childhood (R. Eissler). Second trimester: Special Pathology of the Neuroses (A. Reich); The Dream (S. Kahr); Reading Seminar (C. Davison); General Introduction to Psychoanalysis (R. de Saussure); General Pathology of the Neuroses (L. Eidelberg); Psychology and Pathology of Childhood (R. Eissler). Third trimester: Special Pathology of the Neuroses (A. Reich); The Dream (S. Kahr); Reading Seminar (W. Needles); General Pathology of the Neuroses (L. Eidelberg); Reading Seminar on Adolescence (M. O. Hawkins). *Second Year.* First trimester: Psychoanalysis and Anthropology (G. Roheim); Reading Seminar (K. K. Bluhm); Lectures on Technique (R. M. Loewenstein); The Papers of Abraham, Ferenczi, Jones, *et al.* (R. Fliess). Second trimester: The Place of the Dream in the Practice of Psychoanalysis (O. Isakower); The Papers of Abraham, Ferenczi, Jones, *et al.* (R. Fliess); Continuous Case Seminar (L. Malcove). Third trimester: The Place of the Dream in the Practice of Psychoanalysis (O. Isakower); Psychoanalytic Theory of Psychoses (R. C. Bak); Continuous Case Seminar (L. Malcove). *Third Year.* First trimester: The Place of the Dream in the Practice of Psychoanalysis (Drs. H. A. Bunker and H. Nunberg); Theory and Technique of Child-Analysis (Mrs. B. Bornstein); Seminar in Technique (Drs. E. Kris and R. M. Loewenstein). Second trimester: Clinical Conferences (Drs. S. Atkin, R. Fliess, M. O. Hawkins, R. M. Lowenfeld); Psychopathology of the Infantile Ego (M. S. Mahler); Continuous Case Seminar in Child-Analysis (Mrs. B. Bornstein); Ego Psychology (Drs. E. Kris and R. M. Loewenstein); Continuous Case Seminar (Drs. E. Jacobson and E. Kronold). Third trimester: Clinical Conferences (Drs. H. Nunberg and R. A. Spitz); Problems in Interpretation (B. D. Lewin); Continuous Case Seminar in Child-Analysis (Mrs. B. Bornstein); Continuous Case Seminar (Drs. E. Jacobson and E. Kronold).

Those students who in their third year elect the three trimesters of Continuous Case Seminars in Child-Analysis and who intend to specialize in Child-Analysis are required to take three further trimesters of Continuous Case Seminars in Child-Analysis in the following year as well. Those students who wish to complete the curriculum requirements in Child-Analysis and thereby become eligible for a diploma will be required to take at least two child cases and one adolescent under supervision for two years. For this purpose, the supervising instructors in Child-Analysis are: Mrs. B. Bornstein, Dr. M. O. Hawkins, Dr. M. Kris and Dr. M. S. Mahler.

PHILADELPHIA PSYCHOANALYTIC INSTITUTE

Education Committee consists of the Board of Directors of the Institute: Dr. LeRoy M. A. Maeder (Chairman), Drs. Kenneth E. Appel, Morris W. Brody, O. Spurgeon English, Leon J. Saul.

Training Analysts for the Institute: Drs. Morris W. Brody, O. Spurgeon English, LeRoy M. A. Maeder, Leon J. Saul, Robert Waelder, Ph.D., Margaret S. Mahler (New York).

Candidates in Training, 1949–50: 58—all physicians.

Programme of Courses. First Year: History of Medical Psychology (R. S. Bookhammer); Basic Concepts of Psychoanalysis (L. M. A. Maeder); The Nature of Dreams (M. A. C. Astley); Seminar Discussion of Freud's Early Papers (Drs. M. R. S. Astley and B. Jaffe); Seminar Discussion of Important Papers of Freud (M. W. Brody); Manic-Depressive Psychosis, Schizophrenia, Paranoia (K. E. Appel); Seminar Discussion of Important Papers of Jones, Abraham and Ferenczi (R. S. Bookhammer). *Second Year:* Technique of Analysis (Drs. L. M. A. Maeder, O. S. English and R. Waelder); Freud's Case Histories (Eleanor A. Steele); Pathological Formations—Hysterical, Traumatic and Character Neuroses (B. Jaffe) and Obsessional Neurosis, Delinquency and Personality Disorders (P. Q. Roche); The Interpretation of Dreams (L. J. Saul); Continuous Case Seminar (Drs. R. Waelder and O. S. English). *Third Year:* Clinical Conferences (Drs. M. W. Brody, R. S. Bookhammer, H. Freed, Eleanor A. Steele, O. S. English); Continuous Case Seminar; Cultural and

Group Psychology (H. Freed); Psychoanalysis and Social Institutions (R. H. Abrams, Ph.D.); Critique of Theories of Psychoanalysis (R. Waelder, Ph.D.).

Elective courses can be arranged upon request by a sufficient number of students who have completed their first year's didactic work, on the following subjects: Review of Current Psychoanalytic Literature; Problems of Psychoanalytic Technique; Levels of Development and Character Formation; Theories of Personality and the Projective Techniques; Study of Certain Aspects of the Character: the Voice, Mannerisms of Speech, Figures of Speech, Laughter, Posture.

A special curriculum is provided for students in the Professional School of the Philadelphia Psychoanalytic Institute who desire to study psychoanalytic Child Psychiatry and Child-Analysis. The programme of courses includes: *First Year:* Basic Concepts of Psychoanalysis (L. A. M. Maeder); General Introduction to Child Psychiatry (R. H. Abrams, Ph.D.; W. H. Perloff, M.D., *et al.*); Psychological Testing and Projective Techniques (Baldwin); Child Treatment Center Experience; Clinical Observation and Participation; Clinical Conferences on Diagnosis and Treatment (N. Nixon); Supervised Child Therapy (S. M. Finch, E. A. Loomis and N. Nixon, M.D.); Research Project. *Second Year:* General Introduction to Child Psychiatry II (Drs. K. Buckner, S. M. Finch, E. S. C. Ford, E. A. Loomis and N. Nixon); Child Treatment Center II, continued from first year; Clinical Conferences on Diagnosis and Treatment II; Supervised Child Therapy; Continuous Case Seminar in Child-Analysis (M. S. Mahler); Supervised Child-Analysis (M. S. Mahler); Technique of Child-Analysis (M. S. Mahler). Research Project. *Third Year:* Lectures on Child Psychiatry (A. Loomis, W. H. Perloff, M.D., N. Nixon, M.D., Dr. M. S. Mahler and guest lecturers); Child Treatment Center III; Clinical Conferences on Diagnosis and Treatment III; Supervised Child Therapy III; Continuous Case Seminar in Child-Analysis (M. S. Mahler); Technique of Child-Analysis (M. S. Mahler); Supervised Child Analysis (M. S. Mahler); Thesis Project and Examination. *Elective Fourth Year:* Continuous Case Seminar in Child-Analysis (M. S. Mahler); Supervised Child-Analysis (M. S. Mahler); Research Project; Electives and Special Problems (guest speakers and seminars); Thesis Project and Examination.

A third curriculum is designed for physicians not specialising in psychiatry and for scientific workers with professional qualifications in related fields. Curriculum: Personal analysis and theoretical instruction. Programme of courses. *First Year:* Basic Concepts of Psychoanalysis; Psychoanalysis and Psychosomatic Medicine, General Introduction to Child Psychiatry. *Second Year:* Clinical Conferences on Psychosomatic Medicine; The Nature of Dreams; Seminar Discussion of Freud's Early Papers. *Third Year:* Clinical Seminars on Psychosomatic Medicine; Pathological Formations; Cultural and Group Psychology; Psychoanalysis and Social Institutions; Critique of Theories of Psychoanalysis.

The Extension School of the Philadelphia Psychoanalytic Institute offers instruction for persons trained in other professional fields for purposes other than the psychoanalytic treatment of patients. Courses include elective courses for candidates in training in the Professional School, and for professional groups who desire to utilize the knowledge of psychoanalysis in the theory and practice of their respective fields. *Programme of Courses:* I. *Children and Adolescents:* Psychoanalytic Concepts of Normal Behaviour and Emotional Development; Psychoanalytic Concepts of Personality Function (Eleanor A. Steele); The Pre-School Child (Kathryn Buckner); The Grade School Years (E. S. C. Ford); Adolescence (Earl A. Loomis, jr.); The Personality of the Adult who deals with the Child (Stuart M. Finch); Causes and Types of Maladjustments; Clinical Problems—Diagnosis and Management; Clinical Conferences on Specific Case Material (H. H. Herskovitz); II. *Social Work:* Psychological Factors in Social Case Work; Emotional Factors in Social Case Work; Psychoanalysis and Social Case Work: Seminar (Drs. L. M. A. Maeder, M. W. Brody, M. R. C. Astley); III. *Social Institutions:* Psychoanalysis and Social Institutions (R. H. Abrams); IV. *Criminology:* Psychoanalytic Criminology (P. Q. Roche); V. *Medicine:* Psychosomatic Medicine from the Point of View of the Internist (E. Weiss); Psychosomatic Medicine from the Point of View of the Psychiatrist. History and Development (L. J. Saul); Psychoanalytic Contribution to Upper Gastro-Intestinal Symptomatology (Fischer); Psychoanalytic Contribution to Lower Gastro-Intestinal Symptomatology (Fischer); Psychoanalytic Contribution to Allergic Manifestations (Brandt F. Steele); Psychoanalytic Contribution to Gynecologic Symptoms (E. S. C. Ford); Psychoanalytic Contribution to Cardio-Vascular Symptoms (B. Jaffe); Psychoanalytic Contributions to Skin Conditions (M. W. Brody); Psychoanalytic Contribution to Problems of Endocrinology (W. H. Perloff); Psychoanalytic Contribution to Problems of Obesity (Peltz); Treatment Principles of Psychosomatic Conditions (O. S. English; VI. *Psychoanalytic Psychiatry:* Psychoanalytic Psychiatry (Drs. Carroll, McLaughlin, Schnurer), given at Western Psychiatric Institute and Clinic, Pittsburgh, Pa.

INSTITUTE OF THE PHILADELPHIA ASSOCIATION FOR PSYCHOANALYSIS

1950–51

The Philadelphia Association for Psychoanalysis in its Institute has inaugurated a system of preceptor teaching according to which single or small groups

of students pursue an organized plan of study under the supervision of separate instructors at bi-weekly intervals. This method of teaching aims at greater flexibility than can be obtained by the usual classroom study. Instructors change each semester to permit students a close relationship to a large number of members of the faculty. The teaching itself can be analytic to a degree, through recognition and discussion of the student's resistance to a concept. In addition to didactic teaching there is clinical instruction in continuous case seminars and single supervised analysis. In order to meet all requirements, certain lectures are given and the students are asked to attend scientific discussions and seminars held by analysts from other societies. This method of teaching has been found to offer excellent opportunity for measuring the student's capacity directly and thus doing away with the necessity of making the personal analyst his judge, which dual role may raise insuperable obstacles hindering the analysis or even preventing its completion. This kind of training limits the number of students who can be handled by a given number of instructors but it is felt that the preceptorship method has given greater independence and responsibility to the student and greater freedom to the instructor's individuality. Any undue influence on the part of the instructor has been balanced by the graduate seminars which are a forum for the study of the individual's ideas. Meetings with out-of-town analysts alternate with the discussion by the whole Association of case material and theories presented by members of the Association. Out-of-town speakers during 1950–51 included: Dr. Herman Nunberg (N.Y.): Case Study; Dr. Phyllis Greenacre (N.Y.): Special Problems of Female Sexual Development. Mrs. Berta Bornstein has carried on a continuous case seminar on child-analysis. Dr. Jenny Waelder-Hall, Dr. Richard Sterba and Mrs. Beata Rank are scheduled to speak later in the year.

The Institute has courses for four different groups of students: I. For psychiatrists who desire to specialize in the practice of psychoanalysis; II. For psychoanalytic students who desire to specialize in the practice of psychoanalysis of children; III. For physicians who are not psychiatrists, and for other professional groups—educators, psychologists, sociologists, anthropologists, etc.—who desire to add the specialized knowledge of psychoanalysis to their professional skills; IV. For teachers and other professional persons who desire to learn basic psychoanalytic concepts.

Programme of Courses. I. *Course for Psychiatrists who wish to specialize in Psychoanalytic Therapy. First Year:* Basic Concepts of Psychoanalysis: The Structure of the Mind and the Theory of Instincts (P. Sloane); Clinical Examples (E. Marcovitz); Anatomy of the Personality (J. E. Eichholtz); Clinical Examples (O. E. Raezer); The Ego and the Mechanisms of Defence (G. H. J. Pearson); Introduction to the Psychology of Dreams (G. S. Sprague). *Second Year:* Interpretation of Dreams (G. H. Katz); Scientific Methodology of Psychoanalysis and its Technique (R. Waelder and S. G. Biddle); Psychopathology of the Neuroses, Psychoses, Character Neuroses and Perversions (G. W. Smeltz); Continuous Case Seminars (G. H. Katz and R. Waelder); Psychoanalysis and Social Institutions (P. Blanchard). II. *Course for Psychoanalytic students who wish, after completion of Programme I, to specialize in the Psychoanalysis of Children and Adolescents. First Year:* Introductory Lectures on Children and Children's Problems (G. H. J. Pearson and J. E. Eichholtz); Seminar on Psychological Tests and Testing (Miss Ross); Field and Clinical Work. *Second Year:* Lectures on the Physiology of New-born Infants (E. Rose); Seminar on Education and Educational Disabilities (Dr. Preston and Mr. Ketchum); Introductory Lectures on Child Analysis (Mrs. Sprague, Mrs. Todd, Dr. Pearson, Dr. Katz, Dr. Biddle); Bi-weekly Seminars on Psychoanalysis of Children (Dr. Pearson and Dr. Eichholtz); Bi-weekly Continuous Case Seminar on Psychoanalysis of Children (Mrs. Berta Bornstein); Field and Clinical Work; Conferences with Supervising Instructors. *Third Year:* Bi-weekly Seminars on Psychoanalysis of Children (Dr. Pearson); Bi-weekly Continuous Case Seminar on Psychoanalysis of Children (Mrs. Berta Bornstein); Lectures on Child Guidance Clinics and Community Problems (Dr. Newell); Field and Clinical Work; Conferences. *Fourth Year:* Psychopathology of Adolescents (P. Blanchard); Bi-weekly Seminars on Psychoanalysis of Children (G. H. J. Pearson); Bi-weekly Continuous Case Seminar on Psychoanalysis of Children (Mrs. Berta Bornstein). *Fifth Year:* Bi-weekly Seminars on Psychoanalysis of Children (G. H. J. Pearson); Bi-weekly Continuous Case Seminar on Psychoanalysis of Children (Mrs. Berta Bornstein). III. *Research Psychoanalysis* for physicians not specializing in psychiatry and other professional groups. *First Year:* Introductory Lectures on Children and Children's Problems (G. H. J. Pearson and J. E. Eichholtz); Supervised Reading Programmes and Discussions. *Second and Third Years:* Same as first, second and third year curriculum of Course I. IV. *Course for Teachers* and other professional persons: Seminar for Teachers and Educators (in Philadelphia), 10 sessions; Emotional Development of the Child (in Reading), 6 sessions; Clinical Conferences on Specific Case Material (in Harrisburg), 5 sessions; Seminar Discussion of Clinical Examples of Psychoanalytic Concepts (in Scranton and Wilkes-Barre), 10 sessions; Development of the Personality (for Wilkes College Faculty), 8 sessions; Case Conference on Children from Pre-School Age through Adolescence (in Scranton), 5 sessions; Seminars for a Family Casework Agency (in Wilkes-Barre).

SAN FRANCISCO PSYCHOANALYTIC INSTITUTE

1949–50

Education Committee: Dr. Emanuel Windholz (Chairman), Dr. William G. Barrett, Dr. Bernard Berliner, Professor Erik H. Erikson, Dr. Uno H. Helgesson, Dr. Paul Holmer, Dr. Donald A. Macfarlane, Anna Maenchen, Ph.D., Dr. Stanislaus A. Szurek.

Training Analysts: Dr. William G. Barrett, Siegfried Bernfeld, Ph.D., Bernhard Berliner, Professor Erik H. Erikson, Dr. Uno H. Helgesson, Donald A. Macfarlane, Anna Maenchen, Ph.D., and Douglass W. Orr, M.D., Edith Buxbaum, Ph.D., in Seattle.

Partial training under the auspices of the San Francisco Institute is carried on in Seatle, Washington.

Candidates in training as of July, 1950: 61.

Programme of courses offered by the San Francisco Psychoanalytic Institute during 1949–50. *First Semester:* Seminar: Basic Concepts of Psychoanalysis (S. Bernfeld); Seminar: Libido Theory (D. A. Macfarlane); Clinical Conference (Members of the Faculty); Reading Seminar (M. Somers); Selected Papers by Abraham (B. Berliner); Selected Papers by Ferenczi (Uno Helgesson); Ego Psychology (G. W. Barrett and Norman Reider); Seminar: Dream Analysis (E. H. Erikson); Continuous Case Seminar (E. Windholz); Seminar: Theory of Psychoanalytic Technique (S. Bernfeld); Clinical Seminar on Children and Adolescents (A. Maenchen); *Second Semester:* Seminar on Childhood (E. H. Erikson, A. Maenchen); Seminar: Freud's Studies in Hysteria (D. A. Macfarlane); Clinical Conference (Members of the Faculty); Selected Papers by Abraham (B. Berliner); Selected Papers by Jones (P. Holmer); Seminar: Dream Analysis I (N. Reider); Ego Psychology (W. G. Barrett, S. A. Szurek); Seminar: Dream Analysis II (E. H. Erikson); Continuous Case Seminar (E. Windholz); Seminar: Theory of Psychoanalytic Technique (E. Windholz); Clinical Seminar on Children (A. Maenchen).

The Institute also sponsored two lectures by Dr. Heinz Hartmann and one by Dr. René A. Spitz, as follows: Aspects of Ego Psychology (Dr. Hartmann, March 27, 1950); Discussion on the Theory of Instinct (Dr. Hartmann, March 29, 1950); Autoerotism in the First Year of Life (Dr. Spitz, July 10, 1950).

TOPEKA INSTITUTE FOR PSYCHOANALYSIS

1949–50

Education Committee: Dr. Jan Frank (Director), Dr. Trygve Braatoy (Assistant Director), Dr. William L. Pious (Executive Assistant Director), Drs. Robert Jokl, Karl A. Menninger, William C. Menninger, Hellmuth Kaiser, Ph.D., Otto Fleischmann, Ph.D., Rudolf Ekstein, Ph.D., Hugh M. Galbraith, M.D.

Training Committees. Faculty Committee: Drs. Jan Frank, William L. Pious, Karl A. Menninger, Rudolf Ekstein. Executive Committee: Drs. Jan Frank, William L. Pious, Otto Fleischmann, Karl A. Menninger. Sub-Committee on Non-Medical Training: Drs. Rudolf Ekstein, Milton Wexler, Otto Fleischmann, William L. Pious.

Programme of courses offered in 1949–50. *First Year:* Personology I: Development of Personality; Personology II: Structure of Personality; Historical Survey of the Development of Psychoanalytic Theory; Psychoanalytic Technique, Part I; Observation of Infants, Children and Adolescents (Supervised Conferences.) *Second Year:* Continuous Case Seminars; Personology III: Physiology of the Personality (Instinct Theory); Child Psychology; Psychoanalysis and Education; Psychoanalytic Technique, Part II (Theory); Psychoanalysis of Children, Part I (Clinical Conferences); Psychoanalytic Theory of Pathology; Mechanisms of the Neuroses and Psychoses (Clinical Conferences); Delinquency; Dream Interpretation (Clinical Conferences); Psychoanalytic Theory of Dreams; Psychoanalysis of Children, Part II (Theory). *Third Year:* Continuous Case Seminars; Current Contributions to the Psychoanalytic Literature; Psychoanalytic Methodology; Historical Survey of Divergent Movements in Psychoanalysis; Psychoanalytic Technique, Part III (Clinical Conferences); Research in Psychoanalysis.

The following courses may be offered by special arrangement if requested by a sufficient number of students. Certain of them deal with the interrelationship of psychoanalytic knowledge with knowledge of other fields, while others deal with the application of psychoanalytic knowledge to an investigation of various subjects. A. *Interrelations:* Psychoanalysis in Relation to General Psychiatry; Psychoanalysis and Sociology; Psychoanalysis and Anthropology; Psychoanalysis and other Schools of Psychology; Psychoanalysis and Medicine; Psychoanalysis and Religion. B. *Applications:* Psychoanalytic Study of Mythology and Fairy Tales; Psychoanalytic Study of Wit and Humour; Psychoanalytic Study of Art and Literature; Psychoanalytic Study of Philosophy; Psychoanalytic Study of Psychotherapeutic Methods. C. *Psychoanalytic Literature* (for third-year students only): special studies by students on current or past psychoanalytic literature or other literature which has an important bearing on psychoanalytic theory and practice.

PSYCHOANALYTIC CLINIC FOR TRAINING AND RESEARCH

Faculty of Medicine, Columbia University, New York

No Report on Training yet.

WASHINGTON-BALTIMORE PSYCHOANALYTIC INSTITUTE

Education Committee, Baltimore Section: Dr. Sarah S. Tower (Chairman), Dr. Francis McLaughlin, Dr. A. Russell Anderson, Miss Sadie Fishman (Administrative Secretary).

Washington Section: Dr. Edith V. Weigert (Chairman), Dr. Robert A. Cohen, Dr. Rex E. Buxton.

Training Analysts: Drs. A. Russell Anderson, Samuel Barkoff, Dexter M. Bullard, Rex E. Buxton, Mabel B. Cohen, Robert A. Cohen, Anna C. D. Colomb, Lucile Dooley, Edna G. Dyar, Andrew Browne Evans, Frieda Fromm-Reichmann, Ernest E. Hadley, Alexander Halperin, Lewis B. Hill, Marjorie Jarvis, Francis McLaughlin, Robert T. Morse, Olive Cushing Smith, Amanda L. Stoughton, Sarah S. Tower, Jenny Waelder-Hall, Philip S. Wagner, Edith Weigert, Winifred G. Whitman.

The Washington-Baltimore Psychoanalytic Institute sponsors a Psychoanalytic Study Group in New Orleans, La., where Drs. Samuel Barkoff and Anna C. D. Colomb continue their status as training analysts.

Candidates in training in September, 1950: 45 in the Baltimore section; 71 in the Washington section.

The education programme includes training analysis, theoretical instruction and supervised clinical work (200 hours minimum).

Programme of courses offered in Baltimore. *First Year:* Basic Concepts of Psychoanalysis (F. McLaughlin); Basic Literature of Psychoanalysis (H. W. Loewald). *Second Year:* Pathological Formations (Sarah S. Tower); Literature of Psychoanalysis (A. R. Anderson, F. McLaughlin, P. S. Wagner); Scientific Method (E. E. Hadley); Theory and Technique of Dream Interpretation (E. E. Hadley); Introduction to the Technique of Psychoanalysis (L. B. Hill); Continuous Case Seminar (A. R. Anderson); Clinical Conference (L. B. Hill); Clinical Seminar on the Formation and Strategy of the Opening Phases of Psychoanalysis (T. Benedek); *Third Year:* Technique of Psychoanalysis, Seminar on Current Literature (Sarah S. Tower); Seminar on Dreams (E. E. Hadley); Child Psychiatry and Community Agencies (H. W. Newell); Applied Psychoanalysis (L. Ovesey, A. Kardiner); Continuous Case Seminar (A. R. Anderson); Clinical Seminar on the Formulation and Strategy of the Opening Phases of Psychoanalysis (T. Benedek); Lecture-Discussions on Psychoanalysis as Applied to Children (Jenny Waelder-Hall). *Advanced Students and Associates:* Continuous Case Seminar (P. S. Wagner); Clinical Conferences for Associates (L. B. Hill); Clinical Seminar on the Formulation and Strategy of the Opening Phases of Psychoanalysis (T. Benedek). *For Physicians not training to practice Psychoanalysis and other interested and qualified persons:* Psychotherapy as an Aid in Medical Practice (J. Hartz, R. W. Lidz); Psychotherapeutic Principles in Medical Practice (J. Hartz, R. W. Lidz); Child Psychiatry and Community Agencies (H. W. Newell); Comparative Analysis of Cultures (L. Ovesey, A. Kardiner).

Programme of courses offered in Washington. *First Year:* Basic Concepts of Psychoanalysis (Robert A. Cohen); Seminar on Basic Literature of Psychoanalysis (St. Olinick, assisted by Chaneson); Seminar on Interpretation of Dreams (D. Noble). *Second Year:* Pathological Formations (Robert A. Cohen); Literature of Psychoanalysis (Mabel B. Cohen, assisted by Seminar Leaders Goodrich, White, Will); Scientific Method (E. E. Hadley); Theory and Technique of Dream Interpretation (E. E. Hadley); Introduction to the Technique of Psychoanalysis (R. E. Buxton); The Continuous Case Seminar; Clinical Conference (E. G. Dyar, A. Halperin, M. Jarvis). *Third Year:* Technique of Psychoanalysis (Edith Weigert); Current Literature of Psychoanalysis (Mabel B. Cohen, assisted by Seminar leaders: Berman, Granatir, Yochelson); Seminar on Dreams (E. E. Hadley); Child Psychiatry and Community Agencies (Berman); Applied Psychoanalysis (L. Ovesey, A. Kardiner); Continuous Case Seminar (B. Bullard, R. T. Morse, W. G. Whitman); Clinical Conferences (E. G. Dyar, A. Halperin, M. Jarvis); Child-Analysis; *Advanced students:* Applied Psychoanalysis (L. Ovesey, A. Kardiner); Continuous Case Seminar (F. Fromm-Reichmann); Clinical Conferences (R. E. Buxton).

SOUTH AMERICA

ARGENTINE PSYCHOANALYTIC SOCIETY

(*Asociacion Psicoanalitica Argentina*)

1949

Training Committee: Dr. Angel Garma (President), Drs. C. E. Carcamo, M. Langer.

Training Analysts: Drs. A. Garma, C. E. Carcamo, M. Langer, E. Pichon-Riviere, E. Racker, A. Rascovsky, L. Rascovsky.

Programme of courses held in the Argentine Psychoanalytic Institute: Technical Seminar on Psychoanalytic Technique (C. E. Carcamo); Advanced Seminar on Freud's Work (A. Garma); Child Analysis (A. A. de Pichon-Riviere); Freud's Case Histories (Drs. A. Tallaferro and R. Schlossberg); Psychoanalytic Anthropology (E. Racker); Psychoanalysis of a Case of Obesity (A. A. Rascovsky); Principles of Psychoanalysis and Introduction to Psychoanalytic Technique (L. Rascovsky); Psychoanalytic Psychiatry (E. Pichon-Riviere), held in the Muñoz Foundation.

A series of 13 lectures by members of the Argentine Psychoanalytic Association was given in the Medical Association of La Plata. Dr. A. Garma also presented a series of eight lectures in the University of Tucuman at the request of the University

authorities. Dr. E. Pichon-Riviere gave an abbreviated course on 'Alterations of the Body Scheme in the Course of Psychiatric and Neurological Affections' in the Athenæum of Neurology of Buenos Aires.

BRAZILIAN PSYCHOANALYTIC SOCIETY IN SAO PAULO

1949–50

Board of the Training Institute: Dr. A. Koch (President), Dr. D. Uchoa, Miss V. Bicudo, Dr. H. Mendes (substituting for Dr. Uchoa when the latter could not be present because of professional obligations).

In July, 1950, Dr. Theon Spanudis, former member of the Vienna Society came to Sao Paulo and began work with two candidates.

Candidates in Training during 1948–49–50: 8; 2 were starting analysis, 3 were continuing analysis, 1 was doing clinical work under supervision, 1 moved to Rio to continue training there, and 1 left the field. All but one of the candidates were physicians.

Programme of Courses: Sixty Lectures on: Introduction to Psychoanalysis; Dream Interpretation, Metapsychology, etc. Weekly Seminar of Case Discussion with several members of the group (Dr. A. Koch). Lecture on Freud's *Outline of Psychoanalysis*; Case Seminar (Dr. Spanudis); Five Lectures on the Psychoanalysis of Psychoses (Dr. Uchoa); Lecture on Feminine Adolescence (Miss Bicudo).

CHILEAN PSYCHOANALYTIC SOCIETY

1949–50

Training Committee: Drs. F. Allende-Navarro, R. C. Ganzarain, I. Matte Blanco, A. E. Prat, C. d'A. Whiting.

Training Analysts: Drs. F. Allende-Navarro, R. C. Ganzarain, I. Matte Blanco, A. E. Prat, C. d'A. Whiting, G. Rodriguez.

Candidates in training at the end of 1950: 23.

Owing to pressing demands for training and the lack of a sufficient number of training analysts the courses of lectures until recently had been attended by candidates at various stages of training. For the first time in 1949–50 the Society began to carry out its programme for a four-year course by dividing the candidates into two groups: (1) the first-year students, comprising all who have started analysis and courses of lectures in 1950. This group is made up of 10 candidates of whom 9 are medically trained. (2) The more advanced group, comprising those who started training in previous years. This group is not homogeneous but contains candidates at different stages of training even though they attend the same set of lectures and seminars. This group is formed of 13 candidates. Four members of this group are already treating cases under supervision.

This year one of the training analysts started weekly sessions of group analysis with candidates in analysis with him and one candidate in analysis with another training analyst. The immediate prospects and results appear very encouraging and it is felt that eventually group analysis will be made a regular part of the curriculum.

Programme of Courses: 1949: *Advanced Group:* Lectures on Metapsychology—Melanie Klein's Work and Technique (I. Matte-Blanco); Four Lectures on Dream Analysis (A. E. Prat); Seminars on Revision of Literature on Technique (Dr. R. C. Ganzarain); 1950: *First Year:* A course of 22 Lectures on the Principles of Psychoanalysis (Drs. C. d'A. Whiting and R. Ganzarain); A Course of 22 Lectures on Dream Interpretation and Psychopathology of Everyday Life (A. Prat); *Advanced Group:* 22 Seminars on Cases (C. Whiting); A Course of 22 Lectures on Special Theory of Neurosis (A. Prat); 15 Seminars on Revision of Literature on Technique (R. Ganzarain).

EUROPE

BELGIAN PSYCHO-ANALYTICAL INSTITUTE

(*Association des Psychoanalystes de Belgique*)

1948–49

The Belgian group (7 members) was accepted at the Zürich Congress in 1949. The Society publishes a Bulletin every three months.

Candidates in training in 1948–49: 9; in 1949 8 new candidates started their didactic analysis; 6 candidates began clinical work under supervision.

Regular weekly meetings were attended by members and candidates and the following papers were read: On Suggestion; A Study of the Function of the Super-ego (Mr. M. Dugautiez); On Sublimation (Mr. F. Lechat); Jung's Inductive Words (Mme. Lechat); A Study of Aggression in Boys, 4 clinical cases (Mme. M. Mannoni van der Spoel); Narcissism (Dr. J. Leuba).

Two seminars were established: Psychopathology (Dr. J. van Nypelseer); Applied Psychology (Dr. J. van Nypelseer and Mr. F. Degive).

Discussion groups for students were organized.

Conferences arranged during 1948: Dr. J. Boutonier on Weakness of Willpower (at the Belgian Chamber of Psychotechnicians) and Dr. M. Cenac on Psycho-analysis in the Treatment of Neuroses (at the Université Libre de Bruxelles).

1949–50

Three new candidates were accepted and some physicians not specializing in Psychiatry were admitted as guests to some of the seminars and lectures.

Papers read: Psychosomatic Disturbances (Mr. M. Dugautiez); Neurosis and Religiosity (Mr. F. Lechat); Complications due to Guilt Feelings (Dr.

van der Waals, Netherlands); Normal and Pathological Anxiety (Mr. F. Lechat); Magic Thinking (Mr. F. Lechat); Psychogenesis of Inferiority Feelings (Mr. M. Dugautiez). Two candidates read papers: Physiological Bases of Certain Aspects of Behaviour (Mlle. D. Flagey); On Existentialism (Mlle. L. Cox); Seminars were held by Dr. J. van Nypelseer and Mr. F. Lechat.

Mme. Carton de Tournai was accepted as a training analyst on the basis of her paper: Psychopathogenesis of Weaning.

DUTCH PSYCHO-ANALYTICAL SOCIETY

(*Nederlandsche Vereeniging voor Psychoanalyse*)

1949–50

The training courses and seminars are organized by the Institute. If the candidates are sufficiently advanced they start practical work with patients of the Institute.

Courses on psycho-analysis are regularly organized for physicians and students.

The Institute staff is composed of Dr. H. A. van der Sterren (Director), G. Euwe, Mrs. Groen van Beverwijk, Miss P. Nieboer, Mrs. C. Querido-Nagtegaal, S. J. Vles (psychologist).

Training Committee: Drs. P. J. van der Leeuw, J. Lampl de Groot, R. le Coultre, H. G. van der Waals, Rh. Feith.

Training Analysts: Drs. R. le Coultre, Rh. Feith, H. Lampl, J. Lampl de Groot, H. A. van der Sterren, P. H. C. Tibout, H. G. van der Waals.

Candidates in training during 1949–50: 25.

Programme of Courses: First Year: Survey of Psycho-analytic Theory; Freud's Dream Interpretation (*Three Essays on the Theory of Sex*); Hysteria; Obsessional Neurosis; Perversions; Personality Structure. *Second Year:* Theory of Instincts; Character and Ego Development; Œdipus- and Castration-Complex; Narcissism; Technique; Problems of Child Analysis; Psychotherapy. *Third Year:* General Psycho-analytic Theory of Neuroses; Development of Psycho-Analysis; Indications for Treatment; Psycho-Analysis of Psychoses; Phenomenology and Psycho-Analysis; Derivative Schools of Psycho-Analysis (Jung, Adler, etc.).

FRENCH PSYCHO-ANALYTICAL SOCIETY

(*Société Psychanalytique de Paris*)

1949–50

The French group was accepted at the Zurich Congress in 1949.

The French Society has not yet been able to re-establish a training institute like the one which existed before 1939 but hopes to raise the funds to do so in the coming year.

An *Educational Committee* has been set up and comprises the following: Dr. S. Nacht (President); Mme. Marie Bonaparte; Drs. M. Bouvet, M. Cenac, J. Lacan, Professor D. Lagache, Dr. M. Schlumberger.

The Educational Committee has received about 70 applications for training. More than 30 training analyses are in progress and an equal number of candidates are doing clinical work under supervision. In addition, these candidates meet their supervisor each week in small groups for discussion.

GERMAN PSYCHO-ANALYTICAL SOCIETY

(*Deutsche Psychoanalytische Gesellschaft*)

1949–50

The German Psycho-Analytical Society does not have a psycho-analytic institute of its own. The candidates are trained in the Institute for Psychotherapy under the direction of Dr. F. Boehm. The following courses and seminars were given at the Institute for Psychotherapy by members of the German Psycho-Analytical Society.

Programme of Courses. Winter Semester: Seminar on Freud's Writings; Seminar on the Great Books of World Literature; A Typical Marital Conflict; Seminar on Dreams from the Analyses of Candidates (Dr. F. Boehm); On the Theory of Constitution (Dr. G. Fuhge); Basic Psychiatric Concepts; The Infantile Instinctual Life (Dr. H. March); Seminar on the Papers on Theory of Neurosis; Seminar on Writings on Psycho-Analytic Technique; The Basic Human Drives; Psychotherapeutic, Seminar, report on candidates' own treatment (Dr. C. Mueller-Braunschweig); Early Childhood Development of the Ego and its Relation to the Id (Dr. M. Steinbach); Children's Drawings (Dr. M. L. Werner). *Summer Semester:* Neurology and Psychiatry from the Psychotherapeutic Viewpoint; Seminar on Dreams from the Analyses of the candidates (Dr. F. Baumeyer); Discussion of Anamnesis (Drs. F. Baumeyer, H. March, H. Wiegmann); Case Demonstrations; Seminar on Selected Writings of Freud; Clinical-Technical Seminar with Examples supplied by the Participants; Psychotherapeutic Seminar (presentation of several treatments); Obsessional and Hysterical Personalities (Dr. F. Boehm); Seminar on Freud's Dream Interpretation; Family Constellations in Childhood and their Influence on the Development; Relationship between 'Deep Psychology' and Pedagogy (Dr. K. Draeger); Seminar on Theory of Neurosis (Dr. C. Mueller-Braunschweig); Early Development of the Ego (Dr. M. Steinbach).

ITALIAN PSYCHO-ANALYTICAL SOCIETY

(*Società Psicoanalitica Italiana*)

1949–50

Training Committee: Professor C. L. Musatti, Dr. N. Perrotti, Professor E. Servadio.

Training Analysts: Professor C. L. Musatti, Dr. N. Perrotti, Professor E. Servadio, Dr. C. Modigliani.

Candidates in training in December, 1950: 9.

Dr. N. Perrotti, Professor C. Musatti and Professor E. Servadio have held regular seminars for candidates whose personal analysis was completed. Professor Servadio's seminars were *The Ego and Mechanisms of Defence* (A. Freud); *Technique of Psychoanalytic Therapy* (S. Lorand); *Two Case Histories* (S. Freud).

Princess Tomasi di Palma holds regular courses in Palermo, mainly for doctors and medical students.

Lectures held at the Institute of Psychology, Rome University, during April-June, 1950: On the Unity of Psychology (Dr. N. Perrotti) ; Suggestion and Psycho-Analysis (Dr. N. Perrotti); Critical Stages of Psychic Development (Dr. C. Modigliani); Psycho-Analytic Therapy (Dr. C. Modigliani); Psycho-Analysis, Narco-Analysis and other Methods of Psychological Investigation (Professor C. L. Musatti); On Symptom Formation (A. T. di Palma); The Psycho-Analytic Theory of Instincts (Professor E. Servadio); How a Psycho-Analytic Treatment is carried out (Professor E. Servadio); Criminals and non-Criminals who plead guilty (Dr. R. Merloni).

For three years Dr. N. Perotti has held a very successful course on Dynamic Psychology at the School for Leaders of Social Work, Rome University.

Professor C. Musatti teaches Psychology at the University of Milan where, on request, he has held a series of lectures on Psycho-Analysis for Psychiatrists and Doctors.

Dr. C. Modigliani was invited to take part in a special course on 'New Education' under the auspices of the Roman 'Movement of Civic Co-operation'. He gave a series of lectures on the theme: 'Elements of Psycho-Analysis of the Developmental Age'.

Professor E. Servadio lectured on Psycho-Analytic subjects and answered questions from listeners for the Italian Radio.

INSTITUTE OF PSYCHO-ANALYSIS, LONDON

1948–49

Training Committee: Drs. J. Rickman (Chairman), W. H. Gillespie (Secretary), R. D. Usher, D. W. Winnicott, W. Hoffer, E. Rosenberg, W. C. M. Scott.

All training this year was in London. Nine students finished their training during the year. Seventeen students have started or resumed training during the year and 6 have resigned or have been suspended: a total of 61 students were in training on June 30, 1949. Of these, 45 are medically trained.

There are 6 students of child analysis, of whom 1 is a Member, 4 Associate Members and 1 a candidate.

Programme of Courses, 1948–49 (except where otherwise stated the Lectures and Seminars were for all students). *First Year.* Autumn Term: 8 Lectures on the 'Principles of Psycho-Analysis' (Miss A. Freud and Dr. W. Hoffer); 5 Seminars, Course A (Mrs. M. Milner); 5 Seminars, Course B (Mrs. H. Hoffer). Lent Term: 8 Lectures on the Principles of Psycho-Analysis (Miss A. Freud); 8 Lectures on Child Development (Dr. J. Bowlby); 6 Seminars, Course A (Mr. R. Money-Kyrle); 6 Seminars, Course B (Dr. W. Hoffer). Summer Term: 8 Lectures on the Principles of Psycho-Analysis (Miss A. Freud); 8 Lectures on Technique (Dr. S. Payne); 5 Seminars, Course A (Miss M. G. Evans); 5 Seminars, Course B (Mrs. H. Hoffer). *Second Year.* Autumn Term: 8 Lectures on Clinical Psycho-Analysis (Dr. E. Rosenberg); 4 Seminars, Course B (Dr. S. H. Foulkes); 4 Seminars, Course B (Dr. W. Hoffer); Lent Term: 8 Lectures on Clinical Psycho-Analysis (Drs. Carroll and E. Rosenberg); 8 Seminars, Course A (Dr. M. Balint); 8 Seminars, Course B (Drs. W. Hoffer and S. H. Foulkes). Summer Term: 4 Lectures on Other Clinical States (Dr. E. Stengel); 4 Lectures on Introduction to More Recent Developments (Dr. H. Rosenfeld); 8 Seminars, Course A (Dr. P. Heimann); 8 Seminars, Course B (Drs. S. H. Foulkes & B. Lantos). *Third Year.* Autumn Term: 6 Combined Seminars, Courses A and B (Drs. S. M. Payne and J. Rickman); 8 Lectures on Child Analysis, Course A (Mrs. M. Klein); 8 Lectures on Child Analysis, Course B (Mrs. D. Burlingham); 6 Seminars, Course A (Dr. W. C. M. Scott); 6 Seminars, Course B (Mrs. H. Hoffer). Lent Term: 7 Lectures on Later Developments in Theory (Drs. P. Heimann and J. C. Flugel); 6 Combined Seminars, Courses A and B (Mrs. J. Riviere and Mrs. M. Klein); 5 Seminars, Course A (Drs. D. W. Winnicott and H. Rosenfeld and Miss M. G. Evans); 6 Seminars, Course B (Mrs. H. Hoffer). Summer Term: 9 Lectures on Later Developments in Theory (Dr. J. C. Flugel and Dr. P. Heimann); 6 Combined Seminars, Courses A and B (Dr. W. Hoffer and Miss A. Freud); 5 Seminars, Course A (Mrs. M. Klein); 5 Seminars, Course B (Mrs. H. Hoffer).

1949–50

Training Committee: Drs. J. Rickman (Chairman), W. H. Gillespie (Secretary), Miss A. Freud, Drs. P. Heimann, W. Hoffer, W. C. M. Scott, D. W. Winnicott.

Training Analysts. On June 30, 1950, the following analysts were carrying out training and supervision: Dr. M. Balint, Mrs. D. Burlingham, Miss G. Evans, Professor J. C. Flugel, Dr. S. H. Foulkes, Miss A. Freud, Dr. W. H. Gillespie, Dr. P. Heimann, Dr. W. Hoffer, Mrs. H. Hoffer, Mrs. M. Klein, Dr. B. Lantos, Dr. M. Little, Mrs. M. Milner, Dr. S. M. Payne, Dr. J. Rickman,

Mrs. H. Ries, Mrs. J. Riviere, Mrs. E. Rosenfeld, Dr. H. Rosenfeld, Mrs. M. Ruben, Dr. W. C. M. Scott, Dr. K. Stephen, Dr. H. Thorner, Dr. D. Winnicott.

The death of Dr. Ruth Usher was a serious blow to the training and other activities of the Institute. During the year Dr. Margaret Little was recognized for training.

Candidates in Training. On June 30, 1949, there were 61 students in training; of these, 15 finished their training during the year. The number of students in training on June 30, 1950, was 59 (14 first year, 13 second year, 16 third year). There are 7 students of child analysis, of whom 3 are Associate Members and 4 are candidates. There is one guest student from Australia.

Programme of Courses, 1949–50. *First Year.* Autumn Term: 8 Lectures on The Principles of Psycho-Analysis (Miss A. Freud); 8 Lectures on Child Development (Dr. J. Bowlby); 6 Seminars, Course A (Mrs. M. Milner); 6 Seminars, Course B (Dr. W. Hoffer). Spring Term: 8 Lectures on The Principles of Psycho-Analysis (Miss A. Freud); 6 Seminars, Course A (Mr. R. Money-Kyrle); 6 Seminars, Course B (Dr. B. Lantos). Summer Term: 8 Lectures on The Principles of Psycho-Analysis (Miss A. Freud); 8 Introductory Lectures on Technique (Dr. S. M. Payne); 5 Seminars, Course A (Miss G. Evans); 5 Seminars, Course B (Mrs. H. Hoffer). *Second Year.* Autumn Term: 8 Lectures on Clinical Psycho-Analysis ' Neuroses ' (Drs. B. Lantos and E. Stengel); 8 Seminars, Course A (Dr. P. Heimann); 8 Seminars, Course B (Drs. S. H. Foulkes and B. Lantos). Spring Term: 8 Lectures on Clinical Psycho-Analysis, ' Psychoses ' (Drs. H. Rosenfeld and H. Segal); 8 Seminars, Course A (Dr. M. Balint); 8 Seminars, Course B (Drs. W. Hoffer and B. Lantos). Summer Term: 4 Lectures on Clinical Psycho-Analysis, ' Introduction to More Recent Developments ' (Dr. H. Rosenfeld); 4 Lectures on Clinical Psycho-Analysis, ' Other Clinical States ' (Drs. D. Carroll and W. C. M. Scott); 8 Seminars, Course A (Dr. D. W. Winnicott); 8 Seminars, Course B (Dr. W. Hoffer), *Third Year.* Autumn Term: 8 Lectures on Later Developments in Theory (Dr. Balint, Professor J. C. Flugel, Drs. W. Hoffer and W. C. M. Scott); 6 Combined Seminars (Mrs. M. Klein and Miss J. Riviere); 6 Seminars, Course A (Dr. W. C. M. Scott); 6 Seminars, Course B (Mrs. H. Hoffer). Spring Term: 8 Lectures on Child Analysis, Course A (Mrs. M. Klein); 8 Lectures on Child Analysis, Course B (Miss I. Hellmann); 6 Combined Seminars (Dr. S. Payne and Mrs. E. Rosenfeld); 5 Seminars, Course A (Dr. D. W. Winnicott); 5 Seminars, Course B (Mrs. H. Hoffer). Summer Term: 8 Lectures on Later Developments in Theory (Dr. P. Heimann); 6 Combined Seminars (Drs. S. H. Foulkes and W. Hoffer); 5 Seminars Course A (Mrs. M. Klein); 5 Seminars, Course B (Mrs. H. Hoffer).

SWEDISH PSYCHO-ANALYTICAL SOCIETY

(*Svenska Psykoanalytiska Foreningen*)

Training Committee: Drs. René de Monchy, Alfhild Tamm, Lektor Tore Ekman, Dr. Erik Reinius.

Candidates in Training: In the past year 26 candidates have been trained, among them also candidates trained in Copenhagen by Dr. Niels Nielsen, a regular member of the Swedish Psycho-Analytic Society. Dr. Nielsen was appointed Training Analyst at the Kommunehospital in Copenhagen about a year ago.

SWISS PSYCHO-ANALYTICAL SOCIETY

(*Schweizerische Gesellschaft für Psychoanalyse*)

The Swiss Psycho-Analytical Society functions as a training Institute.

The Training Committee is identical with the Executive Committee of the Society and at present consists of: Drs. P. Sarasin, H. Baenziger, Mr. H. Zulliger, O. Pfister, and Dr. H. Flournoy. Numerous training- and control-analyses are in progress.

Lectures on psycho-analytic subjects in which Freud's psycho-analysis is extensively considered, are offered at the Universities of Geneva, Bern, Zürich, and Basel.

VIENNA PSYCHO-ANALYTICAL SOCIETY

(*Wiener Psychoanalytische Vereinigung*)

1949

The Vienna Psycho-Analytical Society suffered a great loss by the death of its Chairman, Professor August Aichhorn, on October 13, 1949. Under the leadership of the acting chairman, Dr. Alfred Winterstein, arrangements have been made for continuing the work of the Society in the centrally situated rooms. The newly-founded August-Aichhorn Gesellschaft has been able to give financial support.

Training Committee. After the emigration of Dr. Otto Fleischmann to Topeka, Kansas, U.S.A., the Training Committee was reconstituted, with Dr. Alfred Winterstein as Chairman, Dr. Hans Aufreiter, and Dr. Tea Genner.

Programme of Courses. Summer Semester, 1949: Seminar for members and candidates once weekly on Theoretical Problems, once weekly on Technical Problems (Dr. O. Fleischmann; Introductory Course in Psycho-Analysis for candidates, with practical examples (Professor A. Aichhorn and Mrs. R. Dworschak); Introductory Course in Psycho-Analysis for Physicians (Dr. W. Solms at the Psychiatric Clinic of the University, Vienna). *Winter Semester*, 1949–50 : Seminar for members and candidates, once weekly on Theoretical Problems (Dr. H. Aufreiter), once weekly on Technical Problems (Dr. T. Genner-Erdheim);

Introductory Course in Psycho-Analysis for Physicians (Dr. W. Solms, at the Psychiatric Clinic of the University, Vienna); Lectures on the Results and Problems of Freudian ' Deep Psychology ' (Dr. L. Bolterauer, at the Pedagogical Institute, Vienna); Lectures on the Results and Problems of ' Deep Psychology ' (Dr. L. Bolterauer, at the Psychological Institute of the University, Vienna). Special Lectures: Dr. A. Winterstein: Speech for the Goethe Centennial, ' Goethe and Psycho-Analysis '; Obituary for Professor August Aichhorn. Dr. F. J. Hacker (Los Angeles): Guest Lecture : ' On a Case of Anxiety Hysteria '. Miss Hedy Schwarz (London): Guest Lecture: ' Analysis of a Child in the Latency Period '.

ASIA

INDIAN PSYCHO-ANALYTICAL SOCIETY

1948–49

Training Analysts: Dr. K. L. Shrimali; Mr. M. V. Amrith.

Candidates in Training: 15; of these 7 were doing clinical work under supervision.

Programme of Courses: A course of Lectures on Different Psycho-analytical Topics (Dr. E. Ludowyk-Gyomori); Series of Lectures on a Variety of Psycho-Analytical Topics (Mr. R. M. Patel).

Public Lecture: Dr. E. Ludowyk-Gyomori: ' Ten Years After: An Evaluation of the Work of Freud '.

ISRAEL PSYCHO-ANALYTIC SOCIETY

(*Chewra Psychoanalytith b'Erez Israel*)

Educational Committee: Drs. G. Brandt, I. Schalit, A. Smeliansky, M. Woolf.

Training Analysts: Drs. G. Brandt, F. Lowsky, I. Schalit, M. Woolf.

Candidates in Training: 5 in Jerusalem, 6 in Tel-Aviv, 3 in Haifa.

Programme of Courses: Discussions on Casework with Social Workers of the Municipality (Dr. G. Brandt, Jerusalem); Special Course and Seminar for Probation Officers in Israel (Drs. E. Hirsch and E. Gumbel); Psychology and Psychopathology of the Child and Juvenile (Dr. E. Hirsch); Introductory Lectures in Psycho-Analysis (Dr. E. Gumbel); Seminars in Theory for Candidates and Pedagogues (Dr. E. Gumbel); Seminar (in Haifa) for Teachers and Pedagogues (Mrs. A. W. Stadthagen); Theory of Instincts (Dr. B. Gruenspann); ' Three Essays on the Theory of Sex ' (Dr. I. Schalit); Case Discussions for Teachers and Pedagogues (Mrs. A. Weiss-Stadthagen).

For two years a study group of five Haifa analysts has met regularly every six weeks for discussion of cases.

SENDAI PSYCHOANALYTICAL ASSOCIATION

1950

Sendai Psychoanalytical Association offered a summer course on psychoanalysis during the summer of 1950, at Hirosaki University.

The programme was as follows: Introduction to Psychoanalysis (M. Marui); Technique of Psychoanalysis including Child-Analysis (M. Yamamura).

Eighty people attended the course; most of these were physicians and teachers in primary and secondary schools.

II. *LIST OF MEMBERS OF THE INTERNATIONAL PSYCHO-ANALYTICAL ASSOCIATION*

The following amendments and corrections of the list published in Part 4, Volume XXXI, 1950, have been found necessary:

Boston Psychoanalytic Society and Institute

Correct: Murray, Dr. Henry A., 37 Brimmer St., Boston.

Add: Murray, Dr. John M. (*President*), 82 Marlborough St., Boston.

Belgian Psycho-Analytical Society

Add:

Membres candidats

Degive, M. F., 249 rue d'Aerschot, Bruxelles.
Drappier, M. Willy, 23 rue du Formanoir, Bruxelles.
Flagey, Mlle. Danièle, 14 av. Lloyd George, Bruxelles.
Joarlette, Mlle. M., 127 rue Josse Impens, Bruxelles.
Lanser, Mme. Karen, 16 rue St. Alphonse, Bruxelles.
Melotte, Mlle. M. de, 114 rue de Trèves, Bruxelles.
Schoonbroodt, Mlle. L., 13 rue de la Madeleine, Bruxelles.

Dutch Psycho-Analytical Society

Revised full list of Members:

Members

Bos, J. W., Juliansalaan 70, Overveen.
de Busscher, Professor Dr. J., Guinardstraat 14, Gent (Belgium).
Coltof, F., Ieplaan 115, Den Haag.
le Coultre, R., Stadionkade 74, A'dam-Z.
Endtz, A., Haagweg 369, Loosduinen (Haag).
Feith, Rh., Stationsweg 4, Den Haag.
Frijling-Schreuder, E., Nassaukade 88, A'dam-W.
Groen-v. Beverwijk, M., Waldeck Pyrmontlaan 17, A'dam-Z.
Hart de Ruyter, Dr. Th., Olympiaplein 57, A'dam-Z.
Kleyn-v. Wylick, Dr. M., Surinamestraat 27, Den Haag.
Knap-Veeze, A., Leonardostraat 68, A'dam-Z.
Kroon, Dr. D. B., Nassaukade 107, A'dam-W.
Lampl, Dr. H., Haringvlietstraat 39, A'dam-Z.
Lampl-de Groot, Dr. Jeanne, Haringvlietstraat 39, A'dam-Z.

Leeuw, Dr. C. H. v. d., p/a de Erven de Wed. J. v. Nelle, R'dam, postbus 817.
Leeuw, P. J. v. d., Rubensstraat 32, A'dam-Z.
de Levie, H., Burg. Meineszlaan 111, Rotterdam.
Mackenzie-v. d. Noordaa, Dr. M., Reyn. Vinkeleskade 65, A'dam-Z.
Meurs, A. F. W. v., v. Hoogenhoucklaan 28, Den Haag.
Muller, Dr. F. P., Rijnsburgerweg 102, Leiden.
Nieboer, Mej. P., G. v. d. Veenstraat 43, A'dam-Z.
Oerlemans, Dr. A. C., Koningslaan 16, A'dam-Z.
Pool, Mevr. A. S. de, Benoordenh. weg 227, Den Haag.
Rumke, Professor D. H. C., Mariahoek 4, Utrecht.
Spanjaard, J., Paviljoenslaan 11, Haarlem.
Stadt-Bass, Mr. B. C. v. d., Wassenaarseweg 153, Den Haag.
Starcke, Dr. A., Dolderseweg 73, Den Dolder.
Thomee, Mej. A. C., Koninginneweg 5, Haarlem.
Sterren, Dr. H. A. v. d., Koninginneweg 47, A'dam-Z.
Tas, J., Joh. Vermeerstraat 51 b, A'dam-Z.
Versteeg, Dr. P. H., Riouwstraat 162, Den Haag.
Versteeg-Solleveld, C. M., Riouwstraat 162, Den Haag.
Vuyk, Dr. R. Mej., Haringvlietstraat 43, A'dam-Z.
Waals, Dr. H. G. v. d., G. v. d. Veenstraat 81, A'dam-Z.

Aspirantleden

Bastiaans, J., Stadionweg 38, A'dam-Z.
Euwe, G. E., Stadionkade 72, A'dam-Z.
Folkerts, Dr. J. F., G. v. d. Veenstraat 95, A'dam-Z.
Querido-Nagtegaal, C. G., Bachstraat 1, A'dam-Z.
Sterre, G. P. v. d., Joh. Vermeerstraat 47b, A'dam-Z.

Buitengewoon lid

Ongerboer, Mej. P., Benoordenh.weg 227, Den Haag.

Indian Psycho-Analytical Society

Correct: Ramana, C. V., 2701 Wilshire Blvd., Los Angeles 5, California, U.S.A. (*Member*, not *Associate Member*).

Swedish Psycho-Analytical Society

Revised full list of Members:

Honorary Members

Antoni, Professor Nils, Östermalmsgatan 45, Stockholm.
Tegen, Professor Einar, Norrskogsvägen 3, St. Essinge, Stockholm.

Members

Ekman, fil. mag. Tore (*Secretary*), Kärtorpsvägen 25, Stockholm.
Haak, Dr. Nils, Vegagatan 18, Stockholm.
Monchy, Dr. René de (*President*), Stenhuggarvägen 22, Bromma, Stockholm.
Nycander, Dr. Gunnar, Rådmansgatan 9, Stockholm.
Nielsen, Dr. Nils, Kommune Hospitalet, Copenhagen.
Reinius, Dr. Erik, Nyängsvägen 41, Bromma, Stockholm.
Szekely, Dr. fil. Lajos, Zettervallsvägen 35, Nacka, Stockholm.
Tamm, Dr. Alfhild (*Vice-President*), Vendevägen, Lidingö, Stockholm.
Törngren, Dr. Pehr Henrik, Skeppsbron 40, Stockholm.

Associate Members

Ahlström, Doc. Dr. Carl-Henry, Nåsvägen II,, Nockeby, Stockholm.
Bernstein, Dr. Lotte, Lindnerplan 9, Stockholm.
Guettler, fil. kand. Klas, Klövervägen 25, Bromma, Stockholm.
Lamm, Dr. Esther, Östermalmsgatan 77, Stockholm.
Merzbach, Therese, Roslagsgatan 32, Stockholm.
Reiter, Doc. Dr. Paul, Kommune Hospitalet, Copenhagen.
Tjellström, Greta, Hermelinstigen 20, Bromma, Stockholm.
Versteegh-Lind, Dr. Aina, Hjärnegatan 10, Stockholm.

Swiss Psycho-Analytical Society

Add: Steiner, Dr. Hans, Heil- und Pflegeanstalt Herisau/AP (*Member*).

Vienna Psycho-Analytical Society

Add: Fleischmann, Otto, Dr. jur., Menninger Foundation, Topeka, Kansas (*Member*).
Pohek, Miss Marguerite, Vienna I, Hanuschgasse 3 (*Associate Member*).

Sendai Psychoanalytical Society

Correct: Kaketa, Dr. Katsumi, Neurologic Clinic of Juntendo Medical College, Tokyo (*Regular Member*).